Food and Drug Administration Center for Food Safety and Applied Nutrition Office of Special Nutritionals

ARMS#

13418



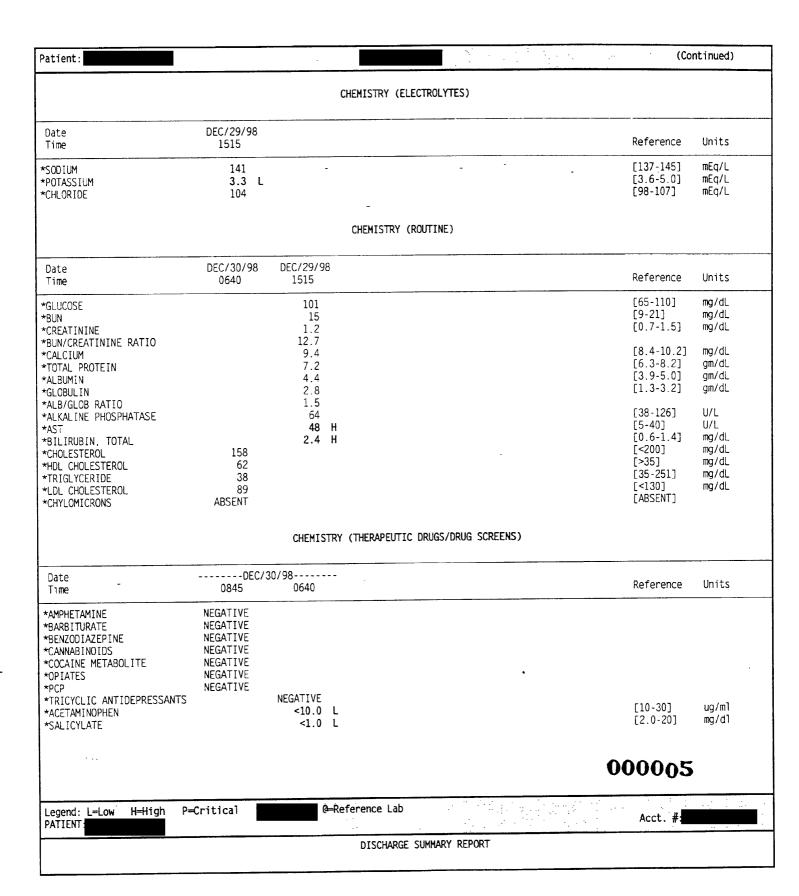
7 - PROCEDURES

FIRST HOSPITALIZATION

PATIENT 29/M	ACCT.#: UNIT.# STATUS:DIS IN	PHYSICIAN REG:12/29/98 DIS:12/30/98	LOC ROOM: BED:	
	HEMATOLOGY	(COMPLETE BLOOD COUNTS)		
Date Time	DEC/29/98 1515		Reference	Units
*WHITE BLOOD COUNT *RED BLOOD COUNT *HEMOGLOBIN *HEMATOCRIT *MCV *MCH *MCHC *PLATELET COUNT	4.7 L 5.21 15.2 45.8 88 29.2 33.2 210 NORMAL		[5.0-10.0] [4.0-5.4] [13.0-16.0] [39-48] [80-96] [26-32] [32-36] [150-450]	K/uL M/uL gm/L % fL pg g/d1 K/uL
*RBC MORPHOLOGY *NEUT *LYMPH *MONO *EOS *BASO	58 31 8 2 2 H		[50-70] [15-40] [0-10] [0-8] [0-1]	% % % %
	HEMATO	OLOGY (COAGULATION)		
Date Time	DEC/29/98 1515		Reference	Units
*PROTHROMBIN TIME *INR	11.2 1.07(A)		[9.0-12.0]	SECONDS
(A) Therapeutic Ram INR 2.0 - 3 Therapeutic Ram INR 2.5 - 3	ige for oral anticoagulant theragon = Protime 22.0 - 33.0 seconge for mechanical prosthetic variety = Protime 28.0 - 39.0 seconge = Protime 28.0 - 39.0 seco	nds 1ves:	[24.1-39.0]	SECUNIOS
(corresponds	28.1(B) nge: APTT = 57 - 95 seconds to 0.3 - 0.7 u/ml porcine hepar ogenic Heparin factor Xa assay)	in.	[24.1-05.0]	SECONDS
	HEMATO	LOGY (MISCELLANEOUS)		
Date Time	DEC/30/98 0640		Reference	Units
*SED RATE	0		[0-15]	mm/hr
			000003	
Legend: L=Low H=High P=	Critical @—Referen	nce Lab	Acct. #	
	DI	SCHARGE SUMMARY REPORT		·

The state of the s

		IIDT	NALYSIS		
		0.11	IVALISIS		
Date Time	DEC/30/98 0845			Reference	Units
URINE COLOR	YELLOW				
URINE APPEARANCE URINE SPECIFIC GRAVIT	HAZY Y >=1.030	-	-	[1.001-1.034	1
MURINE PH MURINE PROTEIN - DIPST	5.0 TICK NEGATIVE			[5-8] [NEGATIVE]	mg/dL
URINE GLUCOSE - DIPST		-		[NEGATIVE]	mg/dL
MURINE KETONE	15 mg/d1			[NEGATIVE]	mg/dL
URINE BILIRUBIN - DIP				[NEGATIVE]	
URINE BLOOD	NEGATIVE			[NEGATIVE]	F 11 741
URINE UROBILINOGEN -	DIPSTI 0.2			[0.2-1.0] [NEGATIVE]	E.U./dL
URINE NITRITE - DIPST				[NEGATIVE]	
URINE LEUK ESTERASE URINE GLUCOSE CLINITE	NEGATIVE ST NEGATIVE			[NEGATIVE]	mg/dL
TURINE MUCUS THREADS	(C)				/lpf
(C) MOD MUCUS	T-READS				
MURINE EPITHELIAL CELL	.S (D)			[FEW SQUAM]	/hpf
(D) RARE SQUA	MCUS				
*URINE RBC	RARE			[0-5/hpf]	
*URINE WBC	5-8			[0-5/hpf]	
*URINE BACTERIA	NONE SEEN				/hpf
		BODY	Y FLUIDS		
Date	DEC/29	0/98			1
Time	1435	1435		Reference	Units
*CSF TUBE #		(E)			
(E) CSF TUBE	#3				
*CSF COLOR -	(COLORLESS			
*CSF CHARACTERISTIC		CLEAR		FA 73	/mm?
*CSF_WBC		1		[0-7]	/mm3 /mm3
*CSF_RBC		5			/ IIIIIS %
*CSF LYMPH	53	100		[40-70]	mg/dL
*CSF GLUCOSE *CSF TOTAL PROTEIN	69 H			[12-60]	mg/dL
CSI TOTAL TROTLIN	03 11				
				00000	4
*				00000	•
	h D Caiti1	@=Reference La	ah		
Legend: L=Low H=High PATIENT	h P=Critical	e-kererence Lo	40	Acct.#	
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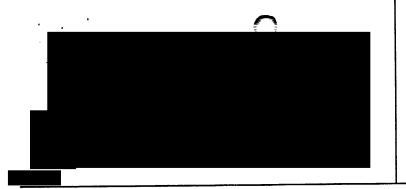


atient:		·					(Continued)
				REFERRAL TESTS			
Date Time		DEC/30/98	0640			Refe	rence Units
ANTITHROMBI	N III, ANTIGENIO	3	24(F) -		-	. [19-	30] mg/dL
(F)	SAMPLE SLIGHTL' See also (@a)	Y ICTERIC.		-			
PROTEIN C (ANTIGENIC)	64(G)				[See	Comment %
(G)	Abnormal Flag: Units: % Decreased leve congenital def	e: 70 OR GREATER L ls of Protein C ar iciency, treatment D.I.C. and post s	t with oral a	found in nticoagulants,			
*RHEUMATOID *ANTICARDIOL		</td <td>11(@a) (H)</td> <td></td> <td></td> <td>[LES</td> <td>S THAN 1 IU/mL</td>	11(@a) (H)			[LES	S THAN 1 IU/mL
	NEGATIVE		NEGATI 14-19	LOW POSITIVE MEDIUM POSITIVE			
	See also (@a)						
*ANTICARDIOL	IPIN IGM AB		(I)				
(I)	NEGATIVE		NEGATI 10-19	nce Range: VE LOW POSITIVE MEDIUM POSITIVE HIGH POSITIVE			
	See also (@a)		- 50	11241110021110			
Test	Date Ti	ime Result	Reference	Units			
*PROTEIN S	12/30/98 06	540 107(J)	[See Comme	ents] %			
(J)	Reference Rang Abnormal Flag Units: % See also (@a)	ge: 70 OR GREATER :					
						000	9006
NOTES: Legend: L=L PATIENT:	ow H -H igh P	=Critical '	@=Refe	rence Lab		Ac	ct. #
				DISCHARGE SUMMARY	DEDODT	<u> </u>	

PAGE 5

Patient:					(Continued)
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Legend: L=Low H=High P=Criti PATIENT:	cal —Refere	ence Lab			ct. #
	[DISCHARGE SUMMARY	REPORT	<u> </u>	

Patient:		(Continued)
Microbiology Specimen Summary		
> 12/30/98 0640 F <	rganisms none> none>	
MICROBIOLOX	GY (ROUTINE CULTURES/SMEARS)	•
Specimen: Collected: 12/29/98-1435 Source: CSF	Received: 12/29/98-1653 Sp Descrip:	
> GRAM STAIN Final 12/29/98 WHITE BLOOD CELLS FEW Neut/100x field ORGANISMS SEEN NONE		
> CSF CULTURE Final 01/01/99 NO GROWTH AFTER 3 DAY	YS	
> CSF CULTURE <i>Preliminary -prev reported</i> NO GROWTH AFTER 2 DAY	YS	
> CSF CULTURE Preliminary -prev reported NO GROWTH AFTER 1 DAY	Y	
MICROBIO	DLOGY (IMMUNOLOGY/OTHER)	
Specimen: Collected: 12/29/98-1435 Source: CSF	Received: 12/29/98-1653 Sp Descrip:	
> BACTERIAL AG PANEL-HAEM.INFLUE Final 12/29/98 HAEMOPHILUS INFLUENZAE B: NEGATIVE		
> BACTERIAL AG PANEL- STR PNEUMO Final 12/29/98 STREPTOCOCCUS PNEUMONIAE: NEGATIVE		
> BACTERIAL AG PANEL-NEIS.MEN A Final 12/29/98 NEIS.MENIGITIDIS ACYW135: NEGATIVE		
> BACTERIAL AG PANEL-N MEN B/EC Final 12/29/98 NEIS MENIGIT.B/E.COLI K-1 NEGATIVE		
Specimen: Collected: 12/30/98-0640 Source: SERUM	Received: 12/30/98-0648 Sp Descrip:	
> ANTI-NUCLEAR ANTIBODY (ANA) Final 12/31/98 ANTI-NUCLEAR ANTIBODY: NEGATIVE		
-		900008
		000008
Legend: L=Low H=High P=Critical *= @=Refero	ence Lab	Acct.
	DISCHARGE SUMMARY REPORT	



NAME:
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UNIT

EXAMS:

HEAD W/O CONT,

HEAD OR NECK ANGIOGRAPHY

MR ANGIOGRAPHY OF THE CIRCLE OF WILLIS VESSELS:

CLINICAL HISTORY: Severe headache, left sided weakness.

3-D time-of-flight MR angiography of the circle of Willis vessels was performed, resulting in 124 images.

Examination is slightly limited due to suboptimal positioning and patient motion artifacts. Apparently the patient could not fully cooperate.

Severe irregular stenosis of the supraclinoid right carotid siphon with occlusion of the right middle cerebral artery at its origin. There is moderately severe stenosis at the origin of the right Al segment. The cavernous segment of the right internal carotid artery is widely patent. The left carotid siphon, left Al and Ml segments are widely patent.

Basilar artery, posterior cerebral arteries and the superior cerebellar arteries are patent. The posterior communicating arteries are not seen and are probably hypoplastic. No definite intracranial aneurysm in the visualized vasculature.

The left anterior cerebral artery is larger than the right. It is not clear if this is due to poor perfusion versus mild congenital hypoplasia.

IMPRESSION:

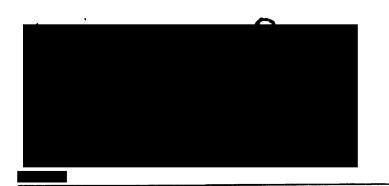
LIMITED STUDY AS DISCUSSED. SEVERE STENOSIS OF THE SUPRACLINOID RIGHT INTERNAL CAROTID ARTERY SIPHON WITH OCCLUSION OF THE RIGHT MIDDLE CEREBRAL ARTERY AT ITS ORIGIN. MODERATELY SEVERE STENOSIS OF THE RIGHT A1 SEGMENT.

THE CAVERNOUS PORTION OF THE RIGHT CAROTID SIPHON, THE LEFT CAROTID SIPHON, LEFT A1 AND M1 SEGMENTS, BASILAR ARTERY AND THE POSTERIOR CEREBRAL ARTERIES ARE WIDELY PATENT.

PAGE 1

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EXAMS:

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HEAD OR NECK ANGIOGRAPHY

<Continued>

ETIOLOGY FOR THIS STENOSIS AND OCCLUSION ON THE RIGHT SIDE IS NOT CLEAR. FINDINGS MAY BE DUE TO DISSECTION, EMBOLUS, OR POSSIBLE VASCULITIS.



MRI OF THE BRAIN, EXTENDED STUDY:

Axial, sagittal and coronal images of the brain were obtained, resulting in 98 images.

CLINICAL HISTORY: As above.

This is a markedly limited study due to suboptimal positioning and patient motion artifacts. The patient could not fully cooperate.

Increased signal in the head of the caudate nucleus on the right, with contiguous extension into the anterior limb of the internal capsule on the right and the anterior right putamen. These findings are best seen on the T2 weighted images and are consistent with recent ischemic change. There is no definite gross infarction of the right middle cerebral artery distribution on this set of limited views. No evidence of herniation. Ventricles are normal in size and configuration. Brain stem and cerebellum appear grossly normal.

IMPRESSION:

MARKEDLY LIMITED STUDY DUE TO PATIENT MOTION AND SUBOPTIMAL POSITIONING.

PROBABLE ACUTE INFARCTION INVOLVING THE HEAD OF THE CAUDATE NUCLEUS ON THE RIGHT, WITH EXTENSION ACROSS THE ANTERIOR LIMB OF THE INTERNAL CAPSULE AND ANTERIOR RIGHT PUTAMEN.

PAGE 2

CHART COPY

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EXAMS: HEAD W/O CONT,

HEAD OR NECK ANGIOGRAPHY

<Continued>

** REPORT SIGNATURE ON FILE 12/31/1998 ** REPORTED AND SIGNED BY:

CC:

TECHNOLOGIST:

TRANSCRIBED DATE/TIME: 12/30/1998 (1611)

TRANSCRIPTIONIST:

PRINTED DATE/TIME: 12/31/1998 (1431) BATCH NO:

CHART COPY





NAME: SEX: M

DATE: 12/30/98 HEIGHT: 5 IN: 1

0/98 IN: 10 WEIGHT: 215

ACCOUNT #

DOB:

ORDERING DR.

UNIT

TYPE OF STUDY: COMBINED/DOPPLER

TECHNICAN:

MACHINE:

SONO I

CLINICAL DIAGNOSIS: TIA, SEVERE HEADACHES REASON FOR STUDY:

TECHNICAL COMMENT: INTERPRETATING DR:

INTERPRETATING DR:

DESCRIPTION: (Normal ranges for adults in parentheses) (Measurements taken from M-Mode tracing)

Mitral Valve E-F slope: >100 mm/sec (greater than 35)

Mitral valve amplitude (D-E): 30 mm (20-35) Posterior mitral valve leaflet movement:

Other mitral abnormalities: Tricuspid Valve: VISUALIZED Pulmonic Valve: VISUALIZED

Aortic Valve: VISOADIZED

Aortic Valve Opening: 2.8 cm (1.6-2.6)

Aortic Root Diameter: 3.3 cm (2.0-3.7)

Left Atrial Dimension: 3.9 cm (1.8-4.0)

Right Ventricular Dimension: 2.0 (0.5-2.1)

Left Ventricular Systolic Internal Dimension: 3.8 cm

Left Ventricular Diastolic Internal Dimension: 5.5 cm (3.5-5.6)

Left ventricular Ejection Fraction: 68 %

LV Shortening Fraction: 32 %

Interventricular Septal Thickness: 1.3 cm (0.7-1.2)

Posterior Left Ventricular Wall Thickness: 1.0 cm (0.7-1.2

Pericardial Effusion:

Pleural Effusion:

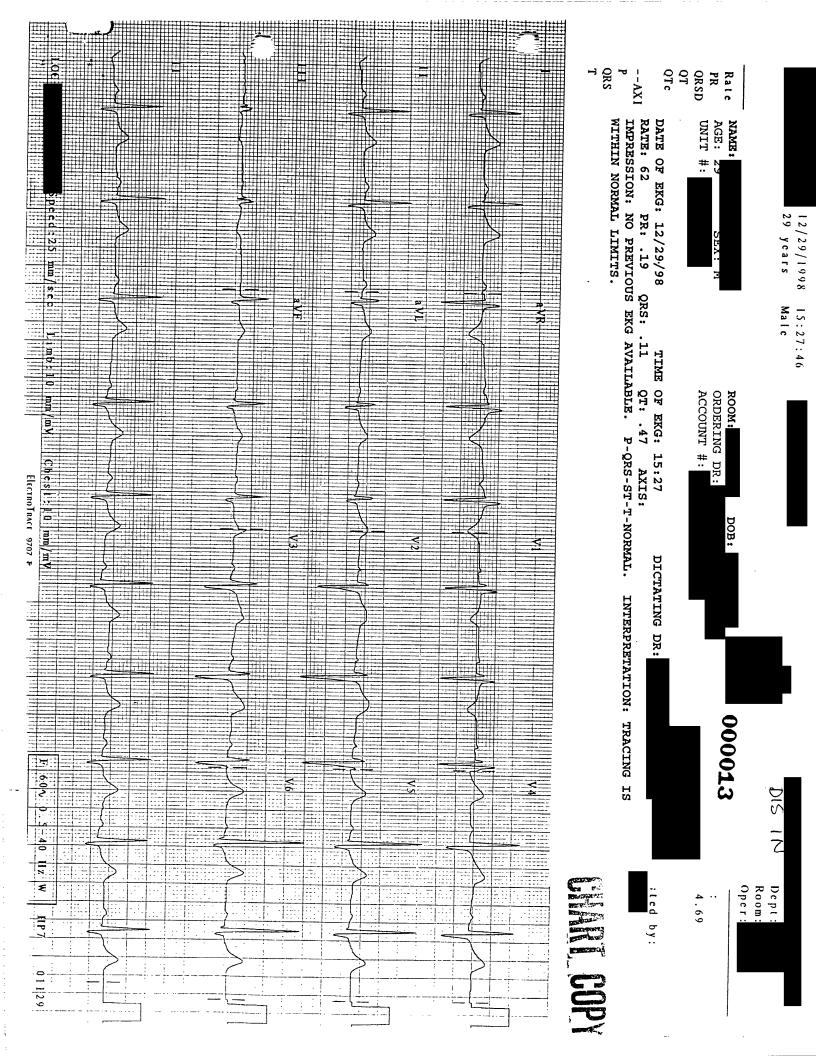
IMPRESSION:

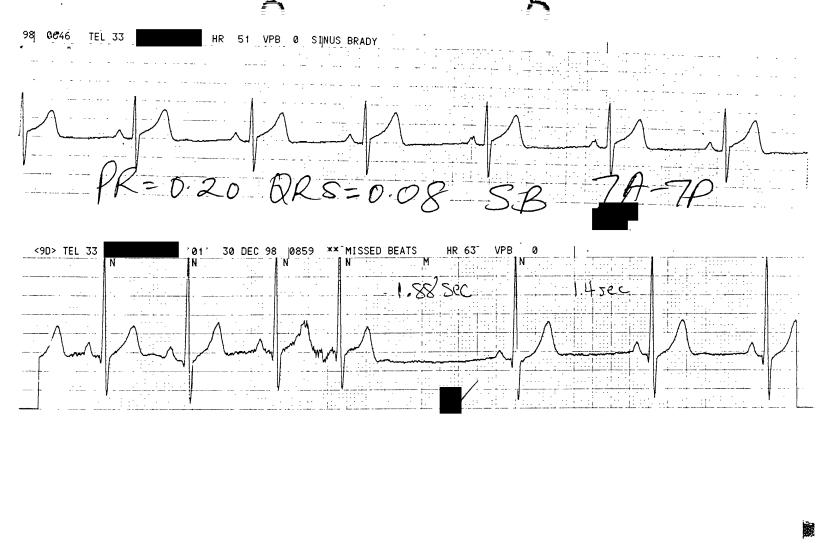
- 1) NORMAL LEFT VENTRICULAR SYSTOLIC FUNCTION WITH AN EJECTION FRACTION OF 75%.
- 2) PROBABLY BICUSPID AORTIC VALVE WITH A MILD TO MODERATE DEGREE OF AORTIC INSUFFICIENCY.

3) NO THROMBUS, VEGETATION OR EFFUSI

12-31-98

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Addressograph

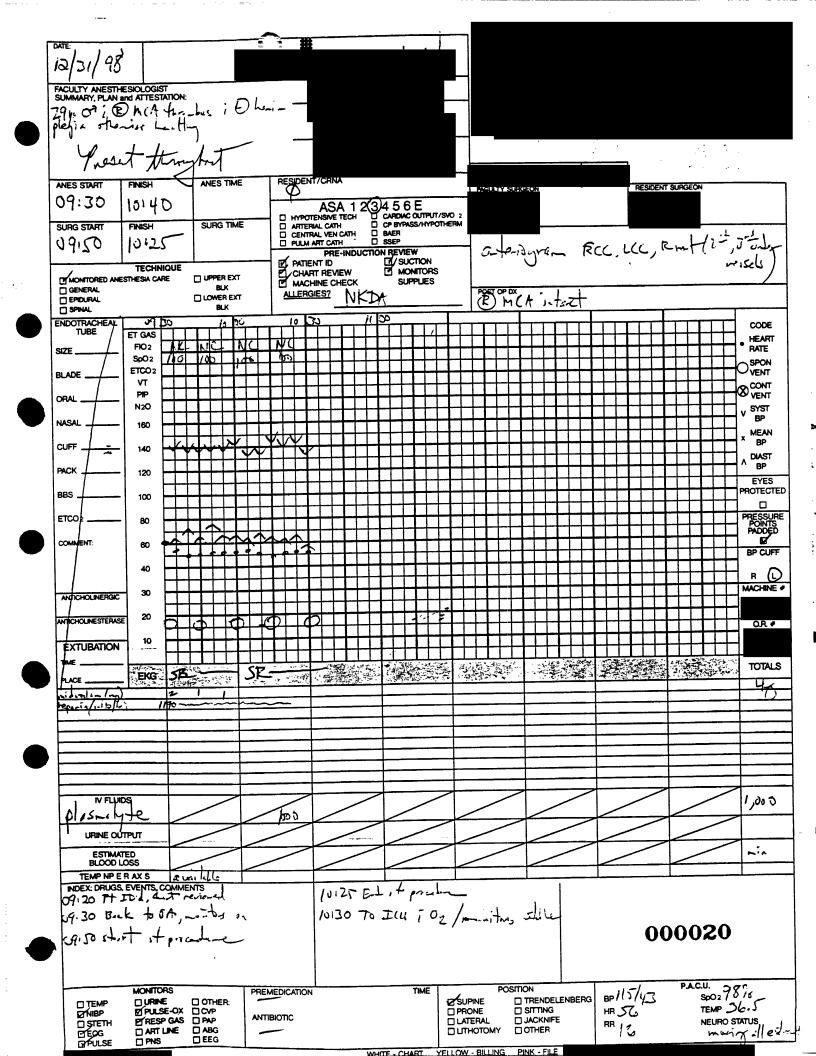
SECOND HOSPITALIZATION

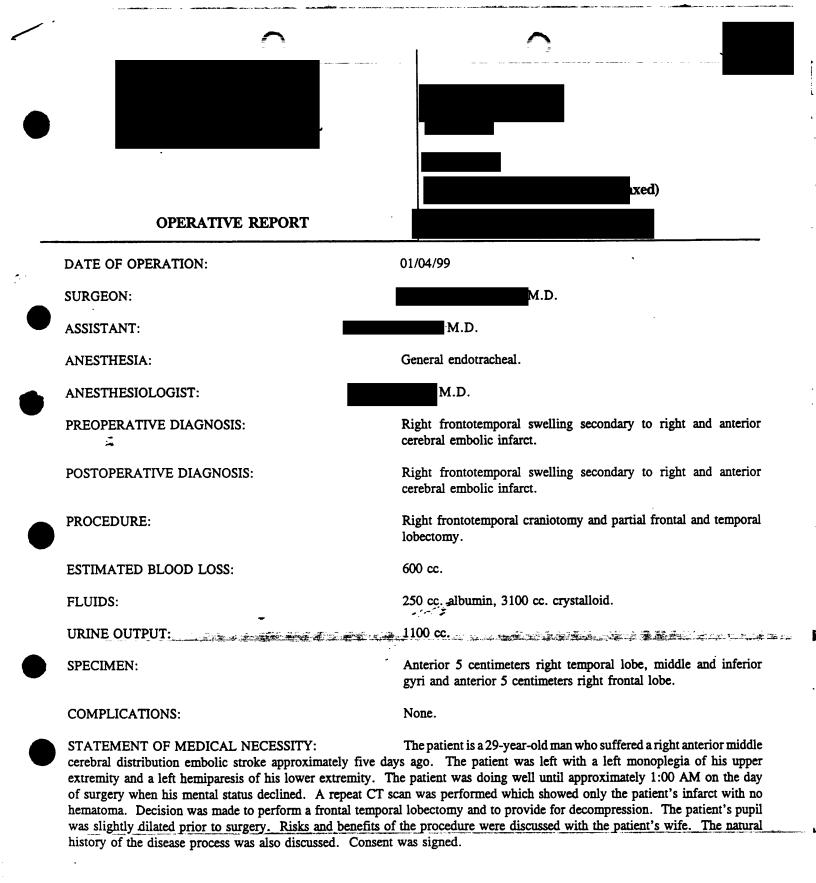
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	SPUD, HH, Lep, GER, Kithing W		AFHX of comple
			ASA 1 2 3 4 5 Œ
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	POST-OPERATIVE NOTE	_ Tirrer _1	9:46
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Approach: Same Special Conditions PT-PTT - 18-2/47-3	Band On:					
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emodynamic Drips - Y / Q recedure: CON In CO CARCUL OGNAM re-op Dx: Stoko sol-op Dx: Stoko out: 1035 End: 1005 adologist: Anesthesiglogist: Resident: corub: RN: RN: RN: RN: RN: RN: RN: RN: RN: RN	•	•			\sim	
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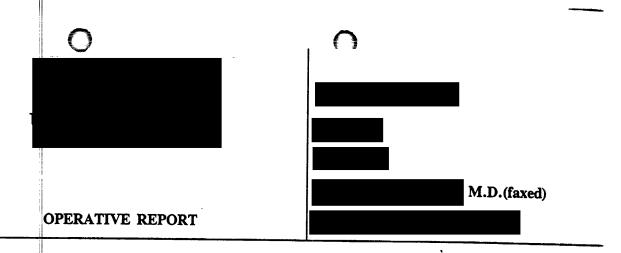
White - Medical Secords Yellow - O.R. Copy Pink - Angiography

	Pre Procedure		· 3		Post Proced	ure		
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DESCRIPTION OF OPERATION: The patient was identified, brought to the operating room and placed on the operating table in a supine position where a member of the anesthesia department administered general endotracheal anesthesia to an already indwelling endotracheal tube. All appropriate monitoring lines were placed. The patient's head was shaved. He was placed in the Mayfield-Kees head holder with the head rotated approximately 45 degrees to the left, the right



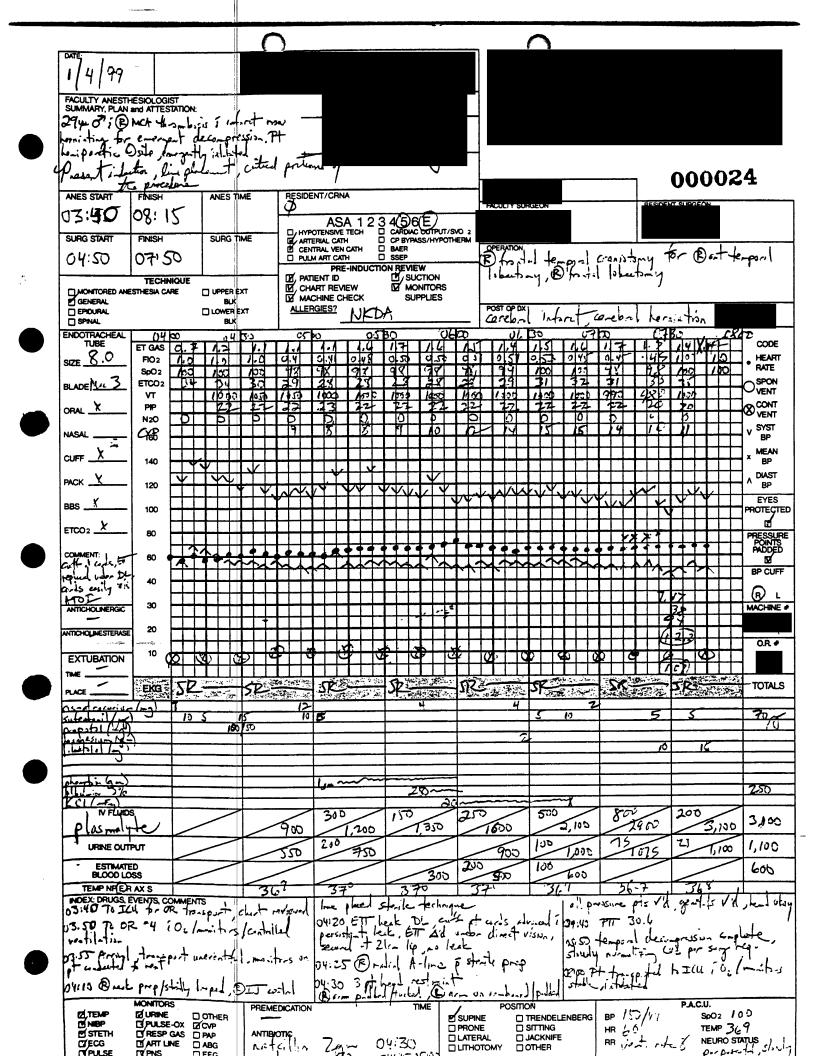
frontotemporal region was prepped and draped in the usual sterile fashion. A cutaneous flap in reverse question mark was reflected anteriorly. Interfascial dissection was carried out to preserve the frontalis branch of the facial nerv temporalis muscle was then reflected inferiorly as a separate flap. We made a cuff on the bone for later reattachment. If flap and the muscle flap were separately retracted with fish hooks. Sponge roll was then placed beneath the skin flap retracting it. A single hole Midas-Rex craniotomy was performed and a frontotemporal bone flap was removed. The sphenoid wing was drilled with the M8 bit and a partial subtemporal and anterior temporal craniectomy was performed dura was firm. The dura was now opened in a curvilinear fashion. It was reflected anteriorly and secured with 4-0 1 tackup sutures.

The underlying brain was full. We first our attention to the temporal lobe. There was a large draining vein running al posterior temporal lobe draining the parietal and posterior frontal cortex. Measurement was made to 5 centimeters which approximately one centimeter in front of this vein. The inferior and middle temporal gyri were then removed in the fashion over to the tentorial edge. We next turned our attention to the frontal lobe. A measurement was made from the tip back 5 centimeters. The surface was cauterized with bipolar cautery and an anterior frontal lobectomy was performe falx. Both the temporal and frontal lobes were sent for histologic evaluation. At the end of the procedure hemostal achieved with bipolar cautery, Surgicel and peroxide. The walls of the cavities were covered with Surgicel. The dura was with interrupted 4-0 Nurulon suture. The bone flap was replaced with three miniplates. No methyl methacrylate was in The entire wound was copiously irrigated with physiologic saline. The temporal muscle was reapproximated with 2-0 suture. The galea was closed with interrupted inverted 2-0 Vicryl suture over a 5 millimeter Jackson-Pratt drain who brought out through a separate stab incision. The skin was closed with skin staples. The drain was secured with a 1 stitch. Sterile dressings were applied. The patient was removed from the Mayfield-Kees head holder, he was transferred to the Intensive Care Unit in critical condition still intubated.

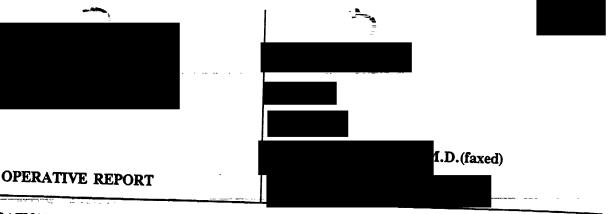
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Please Do Not Separate Page 1 of 3		!					000	,	
8/97 Operat	ting Room Record								



DATE OF OPERATION:

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS:

PROCEDURE:

SURGEON:

ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

FLUIDS:

COMPLICATIONS:

URINE OUTPUT:

SPECIMENS:

01/05/99

Post infarct brain swelling.

Post infarct brain swelling.

Reexploration right frontotemporal craniotomy, additional right frontal and right temporal lobectomy.

General endotracheal.

500 cc.

500 cc.

3,000 cc. crystalloid. Two units of FFP, one unit packed red blood cells.

None.

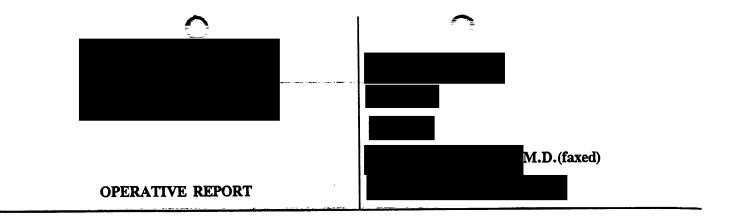
Additional right frontal lobe.

STATEMENT OF MEDICAL NECESSITY: The patient is a 29-year-old right handed white man who suffered a right frontotemporal and parietal infarct along with deep structure infarct secondary to embolic disease. The patient has undergone a previous right frontotemporal partial temporal lobectomy but has had additional brain swelling. He now returns to the operating room for additional surgery. The risks and benefits of the procedure were thoroughly discussed with the family including those of stroke, death and operative failure. Consent was signed.

DESCRIPTION OF OPERATION:

The patient was identified, brought to the operating room, placed on the operating room table in the supine position. Member of the anesthesia department administered endotracheal anesthesia and inserted all appropriate monitoring lines. The patient's head was placed in the Mayfield-Kees head holder and his head was prepped and draped in the usual sterile fashion. The previous reverse question mark incision was reopened. The bone flap was removed and the dura was opened and secured with 4-0 Nurulon tackup sutures. The underlying brain was moderately fully. Additional 3 centimeters of frontal lobe, 2 centimeters of temporal lobe were resected. The resection of the temporal lobe was carried down to the tentorial edge and the frontal lobe resection was carried into the frontal horn of the lateral ventricle to the level of the midline falx. At the end of the procedure the brain was quite slack. No uncal herniation could be seen. The entire cavity was irrigated with physiologic saline and dura was closed with running 4-0 Nurulon suture. The bone flap was replaced with three mini plates. The temporalis muscle was reapproximated with interrupted inverted 2-0 Vicryl suture. The skin was closed with a single layer of nylon.

> Page 1 of 2 CHART COPY



A 7 millimeter Jackson-Pratt drain was left in the subgaleal space. A sterile dressing was applied. The patient was removed from the Mayfield-Kees head holder and returned to the Intensive Care Unit in critical condition still intubated.

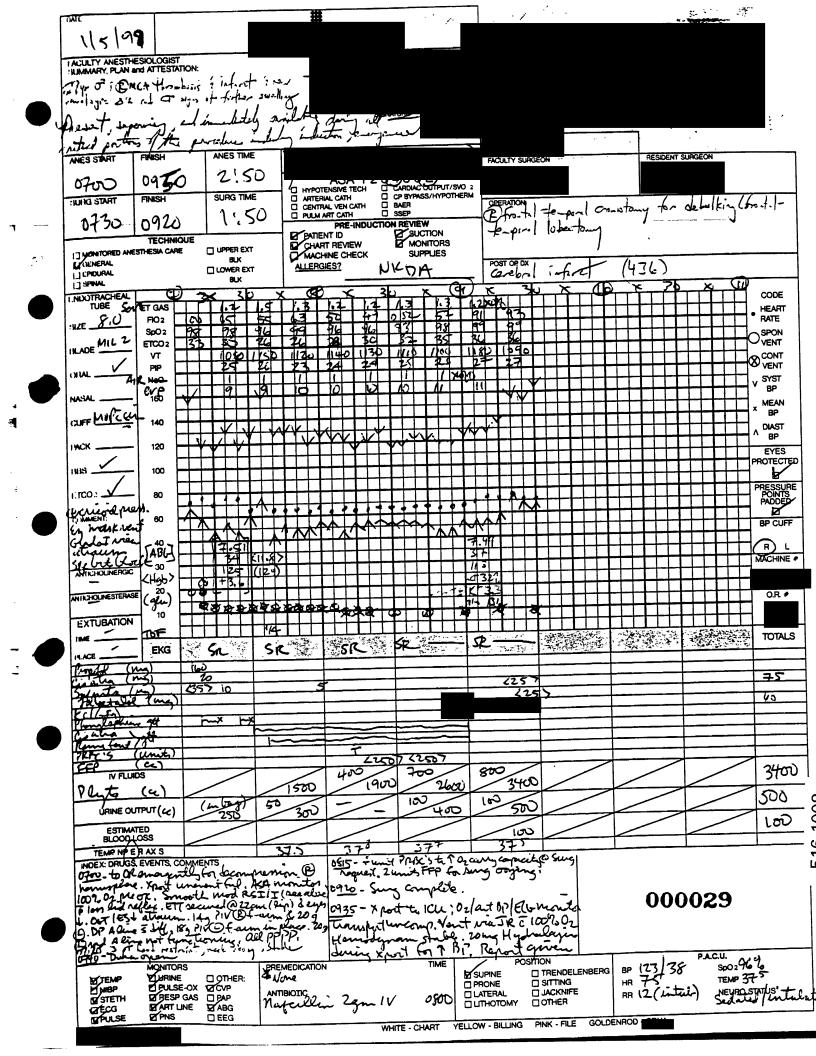
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1-5-99 Emergency OR #. NKDA <u>.</u> ☐ Sedated Unresponsive □ Drowsy LOC: ☐ Alert ☐ Awake ☐ Oriented x 3 ☐ Disoriented ☐ Red/Excoriated Intact Cyanotic Warm/Dry ☐ Cool/Moist Skin Condition: Other ... ☐ Full ROM Limited ROM ☐ Prosthesis Musculo/Skeletal; □ Track/ETT Cardio/Pulmonary: ☐ Unremarkable Drainage \$1000 Foley Chest Tube ☐ NGT □ N/A Drains/Packs: Peripheral IV ☐ Type Lines: CV/Swan Arterial ☐ Apprehensive Psychosocial: ☐ Calm ☐ Anxious ☐ Hearing impaired ☐ Visually impaired Communication: ☐ No apparent limitation ☐ Language barrier Side Rails 1 X & Stretcher Via: C Bed Arrival from: DS ☐ Pre-op Holding Z ICU 0945 736 Surgery End 0976 Room Out Room In Surgery Start. Assistants/Other: **CRNA** Anesthesia: Dr. ☐ Spinal Block Type: CRNA Dr. ☐ IV Sedation CRNA Erel-12 Pre-Op Dx: -1-15 Post-op Dx: 100030 Out 0945 In Charles Out Ogg Terrub Person/s Circulator/s Specimens: ☐ None Routine Frozen Culture

000030 Implants: None ☐ Yes: See Implant Record

Please Do Not Separate

Other

8/97 Operating Room Record

PATIENT:
MRN:
VISIT #:
PMH MRN:
DOB:
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ADM MD:
ADM DATE:
PT LOC:
ROOM:

FINAL

REFERRING PHYSICIAN:

EXAM:

SPECIAL PROCEDURE

DATE: / 01/06/99

TIME: 2023

ACCESSION #

REPORT

DATE OF SERVICE: 01/06/99; 2023.

PROCEDURE PERFORMED:
Pulmonary arteriogram.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

The patient is a 29-year-old man who had a catastrophic intracranial event while weightlifting. He has undergone several intracranial procedures, the most recent of which is a hemispherectomy performed earlier today. During this procedure, the patient became hypotensive and hypoxemic. The possibility of pulmonary embolic disease causing this acute decompensation is considered, clinically likely, and therefore a pulmonary angiogram is requested. Because the patient cannot be heparinized, a vena caval filter is requested if the pulmonary arteriogram shows the presence of pulmonary embolic disease. Informed consent is obtained from the patient's wife and family as the patient could not give informed consent because of his current depressed mental status.

The patient is transferred to the angiography table and the right groin is prepped and draped in a sterile fashion. With single wall puncture technique, the right common femoral vein is entered and an .038 3 mm J guide wire is advanced into the inferior vena cava. A 7.5 French AP #2 catheter is advanced over the guide wire into the right heart and manipulated without difficulty into the left main pulmonary artery. Films are obtained of the left pulmonary circulation in the LAO and LPO projections. The catheter is then repositioned in the right pulmonary artery and films of the right pulmonary circulation are obtained in the AP and right anterior oblique projections.

A review of the images shows a normal appearance of the pulmonary arterial and venous circulation. The pulmonary parenchymal phases are normal bilaterally. No evidence of pulmonary embolic disease is present at this time.

After concluding the diagnostic procedure, the catheter is withdrawn and

MEDICAL RECORDS COPY

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DEPARTMENT OF KADIOLOGY

PATIENT:
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FINAL

EXAM:

SPECIAL PROCEDURE

DATE: 01/06/99

TIME: 2023

ACCESSION #

MCCMDD TON II

REPORT

manual compression maintained at the right groin until hemostasis is obtained. The patient is transferred back to the intensive care unit bed and returned to the intensive care unit in good condition without evidence of complication.

The results of the procedure are communicated to Dr. who was present at the conclusion of the procedure.

IMPRESSION

IMPRESSION:

Normal bilateral selective pulmonary arteriogram without evidence of pulmonary embolic disease.

Dictated by:

M.D.

D: 01/07/99; 0847

Job

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SIGNED BY:

RESIDENT ID:

M.D.

T:

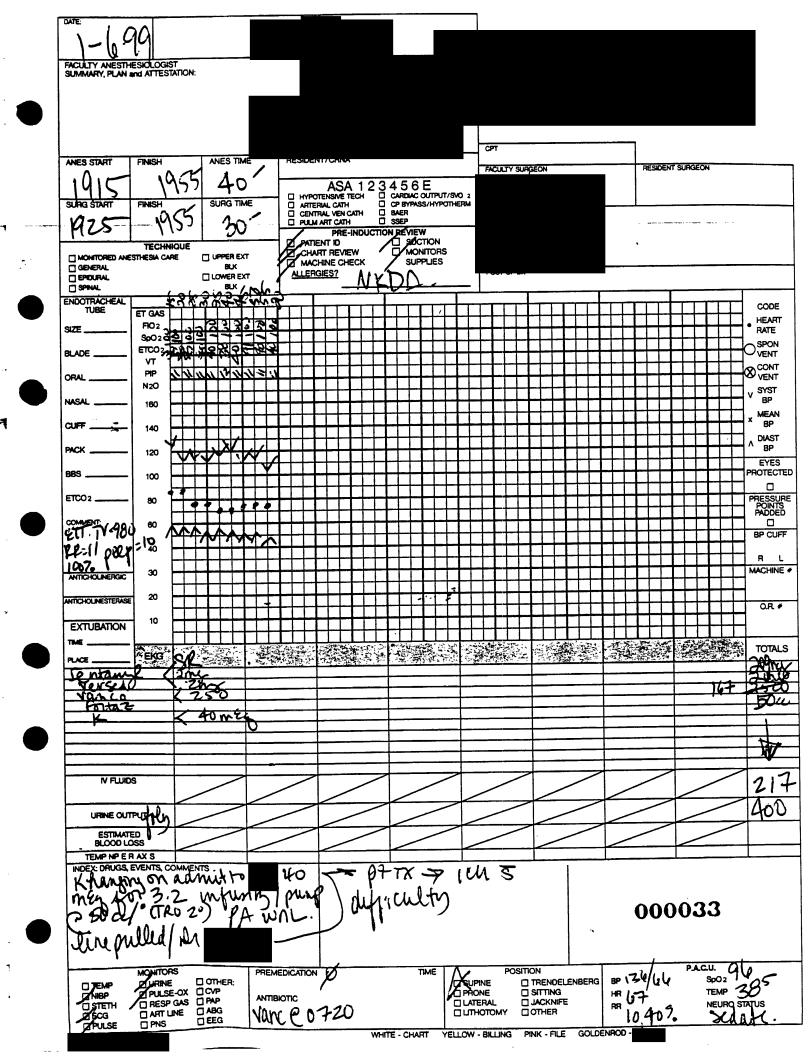
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MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

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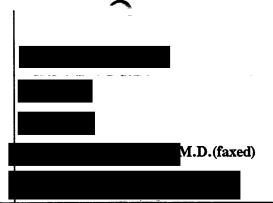
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White - Medical Records

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OPERATIVE REPORT

DATE OF OPERATION:

01/06/99

PREOPERATIVE DIAGNOSIS:

Post-infarct brain swelling.

POSTOPERATIVE DIAGNOSIS:

Post-infarct brain swelling.

PROCEDURE:

Right hemispherectomy.

STAFF SURGEON:

M.D.

FELLOW SURGEON:

ANESTHESIA:

General endotracheal anesthesia, Dr.

COMPLICATIONS:

None.

SPECIMENS:

Right frontal, parietal and temporal lobes.

ESTIMATED BLOOD LOSS:

4000 cc.

URINE OUTPUT:

650 cc.

FLUIDS:

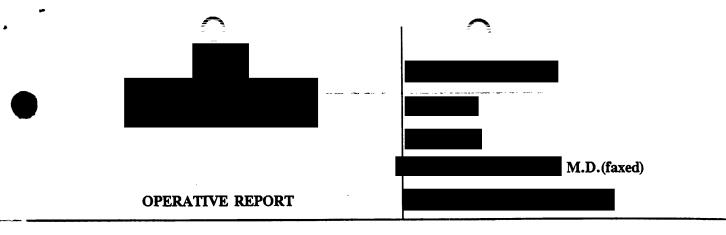
Crystalloid 3500 cc, colloid 1000 cc, packed red blood cells 5 units, FFP

7 units.

The patient is a 29-year-old who has undergone two previous right-sided INDICATIONS FOR OPERATION: operations for brain decompression. He has had continued swelling with evidence of a brain stem compression despite removal of his uncus and frontal lobe to the level and into his right frontal horn. MRI scan has showed complete infarct from previous embolic disease of the right side, and the decision was made to do a right hemispherectomy. Consent was obtained from the family prior to performing the procedure. The risks and benefits of the procedure were thoroughly discussed including stroke and death.

OPERATIVE PROCEDURE: The patient was identified, brought to the operating room and placed operating room table in a supine position where a member of the anesthesia department administered general endotracheal anesthesia. The patient's head was placed in the Mayfield-Kees headholder. His head was prepped and draped in the usual sterile fashion. The previous incision was reopened and secured with fishhooks. The bone flap was removed. Additional bony removal was carried out posteriorly to expose the posterior parietal and occipital lobes. Using bipolar cautery and suction, a hemispherectomy was carried out. The parietal lobe was resected to the level of the falx. Occipital lobectomy was carried out and a completely temporal lobectomy was carried out. The ependyma of the frontal horn was exposed as was the ependyma of the trigone. The frontal parietal cortex covering the basal ganglia, internal capsule and thalamus was suctioned free leaving the deeper structures intact. At this point we looked down toward the incisura. There was no gross herniation seen. The incisura, however, was opened to further decompress the patient's brain stem. Having completed the hemispherectomy, hemostasis was achieved with

> Page 1 of 2 **CHART COPY**



bipolar cautery. Surgicel was left on the exposed raw brain. Two ventriculostomies were left in the cavity. The entire cavity was filled with physiologic saline. The dura was now closed with running and interrupted 4-0 Nurulon sutures. The bone flap was replaced with miniplates. The temporalis muscle was secured with 2-0 Vicryl suture. A 7 mm Jackson-Pratt drain was left beneath the galea. The skin was closed with a running 2-0 Ethilon suture in a locked fashion. It should be noted that tackup sutures were placed through the dura into the bone flap. Sterile dressings were applied. The patient was removed from the Mayfield-Kees headholder. He was transferred to the intensive care unit in critical condition still intubated.

M.D.(faxed)

f.D.

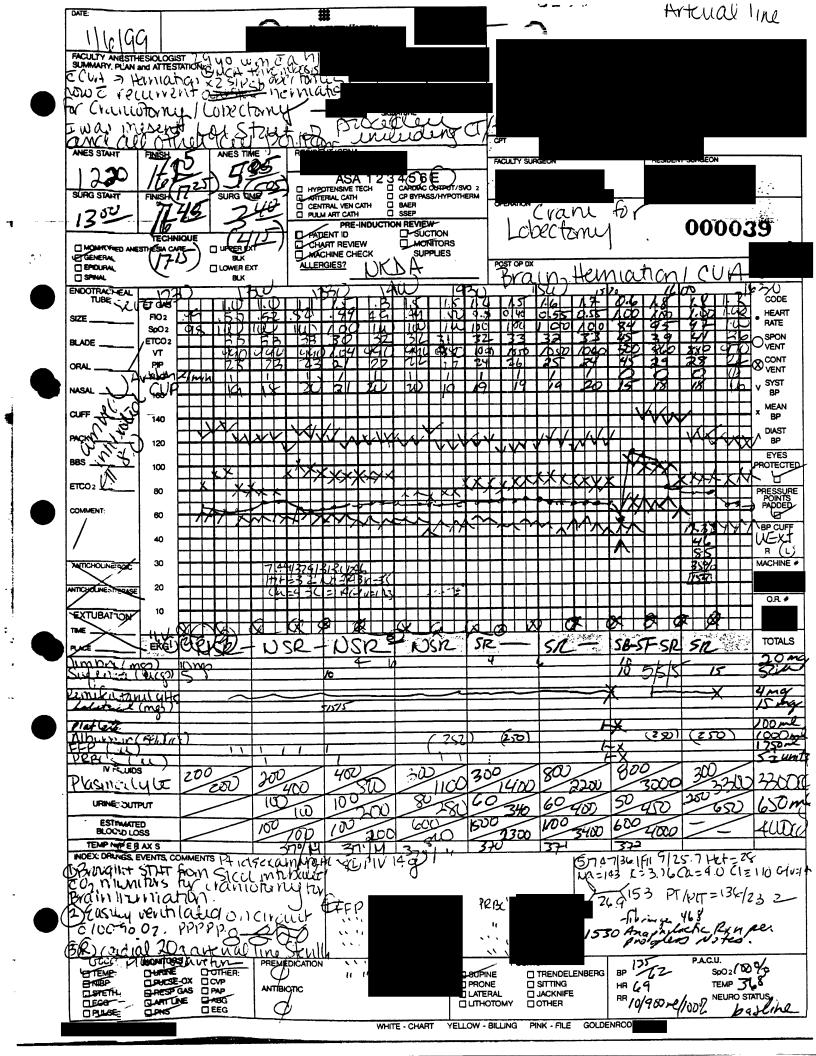
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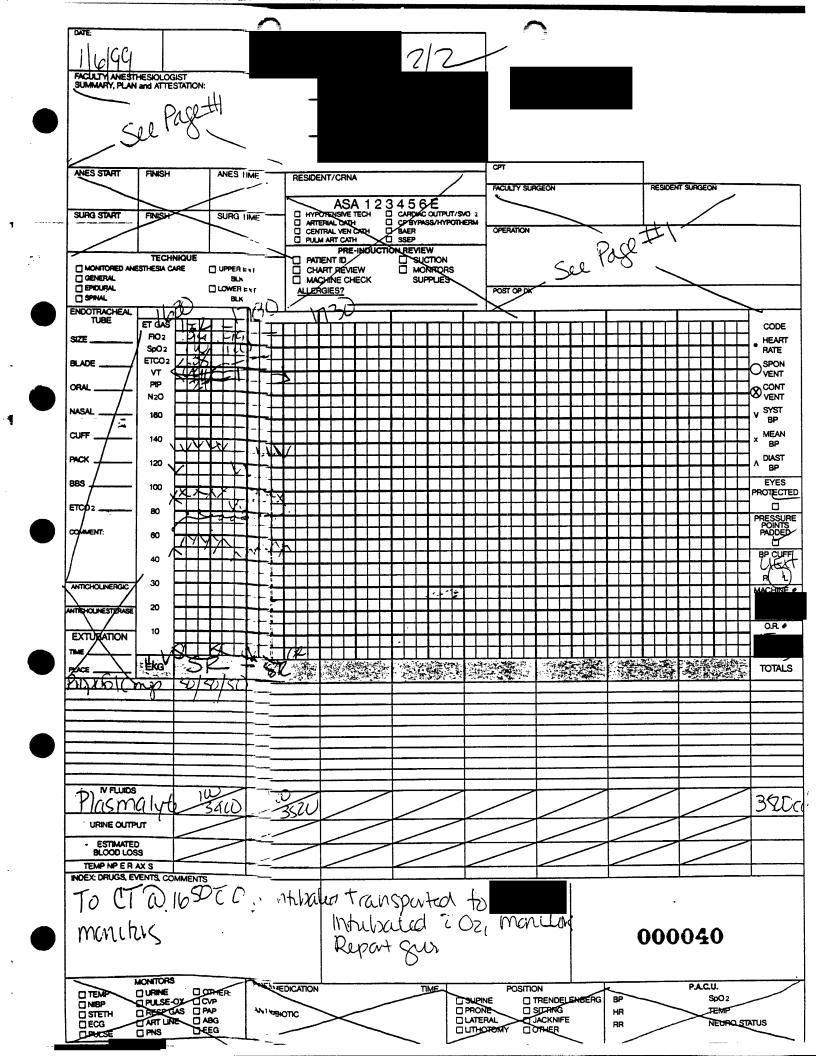
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Page 2 of 2 CHART COPY

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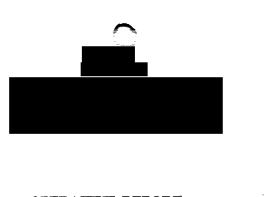


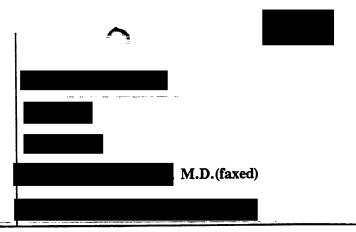
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A.E. ..

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Page 1 of 3
8/97 Operating Room Record





OPERATIVE REPORT

DATE OF OPERATION:

01/15/99

PREOPERATIVE DIAGNOSIS:

Hydrocephalus.

POSTOPERATIVE DIAGNOSIS:

Hydrocephalus.

PROCEDURE:

Placement of medium pressure right parietal ventriculoperitoneal

shunt.

SURGEON:

M.D.

ASSISTANT:

ANESTHESIA:

General endotracheal.

ESTIMATED BLOOD LOSS:

Less than 50 cc.

URINE:

Not measured.

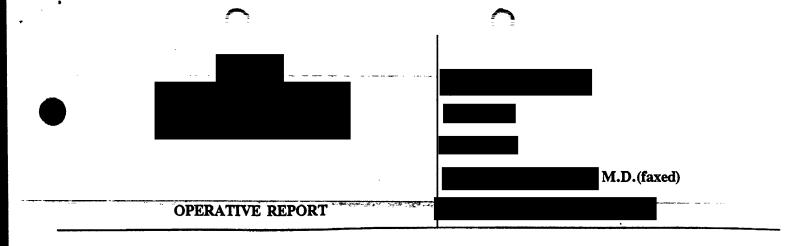
IMPLANT DEVICE:

Medium pressure valve.

The patient is a young gentleman in his 20s who suffered a large STATEMENT OF MEDICAL NECESSITY: right MCA infarct of unknown etiology. The patient underwent three brain resections ultimately requiring a complete hemispherectomy to control brain swelling. The patient has been at his baseline neurologic condition since admission. He has developed hydrocephalus which has not been amenable to weaning of an external ventricular drain. The benefits and risks of ventriculoperitoneal shunting were discussed. The family signed consent.

DESCRIPTION OF OPERATION:

The patient was identified, brought to the operating room and placed on the operating table in a supine position. A member of the anesthesia department administered general endotracheal anesthesia and inserted all appropriate monitoring lines. The patient's head was shaved and his head, neck, chest and abdomen were prepped and draped in the usual sterile fashion. We first turned our attention to the abdomen. A midline incision extending approximately four centimeters just below the level of the xiphoid was made. This extended down and self retaining retractors were inserted. The abdominal fascia was opened. The preperitoneal fat was retracted. The peritoneum was grasped with two mosquito clips. The peritoneum was opened. A #4 dissector was advanced through the hole of the peritoneum to prove that we were indeed in the peritoneal cavity. At this point we turned our attention to the head. A small incision was made in a curvilinear fashion over the right parietal area. Raney clips were applied to the skin edges. A bur hole was made. The dura was cauterized and opened in a cruciate fashion. A previously assembled shunt at a length of 10 centimeters was inserted into the right cavity where hemispherectomy had been performed. The shunt was then passed beneath the skin using a shunt passer. It pumped and refilled well. It was inserted into the peritoneal cavity. A pursestring suture through the peritoneum closed the peritoneal hole. The entire wound was copiously irrigated with physiologic saline. Antibiotic saline was also used. The fascia was closed with interrupted 2-0 Vicryl sutures. The subcutaneous tissue was closed with interrupted inverted 2-0 Vicryl suture and the skin was closed with a running nylon stitch.



At the cranial end the entire wound was copiously irrigated with physiologic and antibiotic saline. The galea was closed with interrupted inverted 3-0 Vicryl suture. The skin was closed with skin staples. A separate stab incision in the scalp was not necessary. Sterile dressings were applied. The patient was transferred back to the Intensive Care Unit in stable condition.

M.D.(faxed)

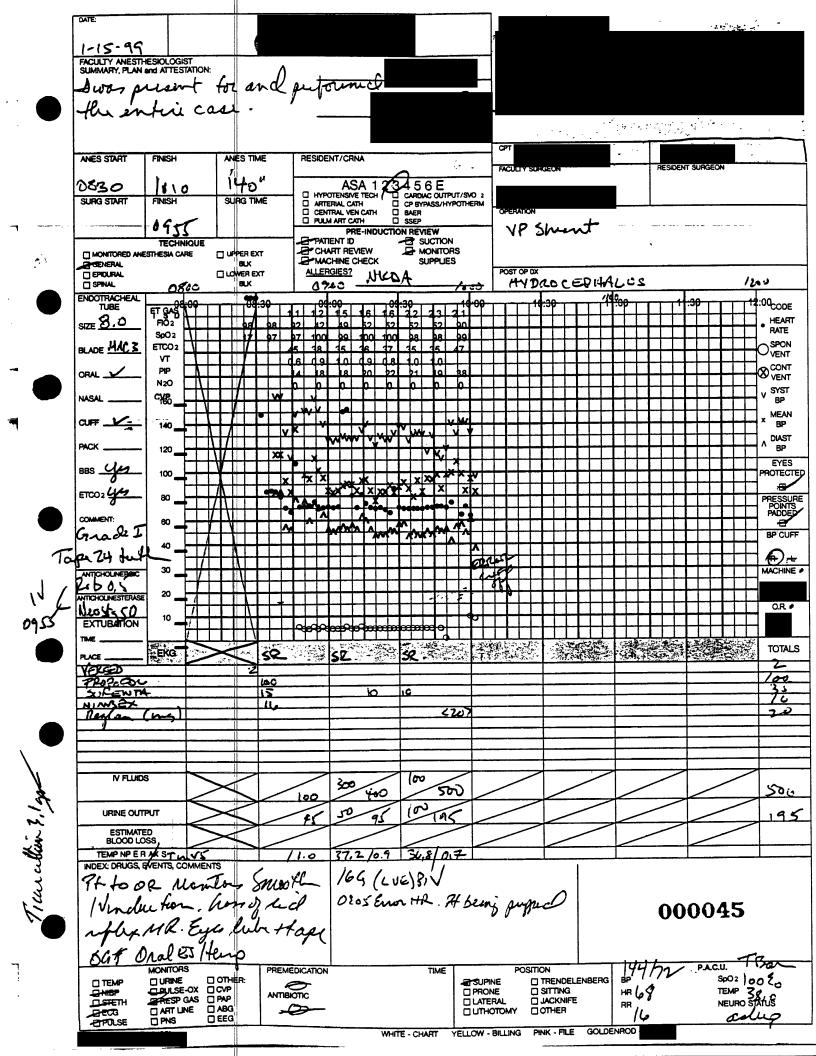
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Date of Operative Procedure:

Physician:

Service: NEUROSURGERY

Date received: 010499

Surgical Pathology No.:

CLINICAL HISTORY/OPERATIVE DIAGNOSIS

29 y/o post stroke. Source of specimen: 1. Right anterior temporal lobe. 2. Right frontal lobe. Clinical impression: Right cerebral vascular accident.

GROSS EXAMINATION:

The first specimen, received in formalin, labeled with the patient's name and RIGHT ANTERIOR TEMPORAL LOBE (POST STROKE), consists of a $4.7 \times 3.2 \times 1.8$ cm segment of brain with flattened gyri and sulci. Several punctate, red areas are seen at the gray-white junction. Sections are submitted as (A1)-(A5).

The second specimen, received in formalin, labeled with the patient's name and RIGHT FRONTAL LOBE (POST STROKE), consists of a 6.8 x 5.5 x 2.7 cm segment of brain with flattened gyri and sulci. Blood is present in the subarachnoid space. At one side there is a 0.8 x 0.8 x 0.8 cm collection of clotted blood dissecting the gray-white junction. The sulci near the lesion also contains clotted blood. The remaining parenchyma is notable for punctate, red-purple lesions most notable in the white matter near the surgical resection margin. GROSS PHOTOGRAPHS ARE TAKEN. Sections are submitted as follows: Cassette (B1) dissected blood, (B2)-(B5) sections of brain from close to lesion to far from lesion.

MICROSCOPIC DIAGNOSIS:

1. AND 2. RIGHT INTERIOR TEMPORAL LOBE AND RIGHT FRONTAL LOBE OF BRIAN (RESECTION):

MULTIFOCAL PARENCHYMAL RARIFICATION WITH ACUTE NEURONAL INJURY AND RECENT HEMORRHAGE, CONSISTENT WITH INFARCTS (SEE COMMENT).

COMMENT:

Occasional foci show histiocytes, consistent with early organization. No evidence of neoplasm, vascular malformation, or other obvious etiologies for the hemorrhage are seen.

I reviewed the diagnostic material; this is my interpretation. Date typed: 010799 M.D.

0914 hours

PATHOLOGIST ELECTRONIC SIGNATURE

Surgical Pathology No.: Date received: 010499 I UNIT

000048

Electronically Signed Out By: M.D.

Data of Operative Procedure: Physician: Service: NEUROSURGERY Date received: 010599 Surgical Pathology No.: CLINICAL HISTORY/OPERATIVE DIAGNOSIS 29 y/o s/p stroke. Re-exploration craniotomy. GROSS EXAMINATION: The specimen, received in formalin, labeled with the patient's name and FRONTAL LOBE, consists of a wedge-shaped cerebral cortical resection which measures 5.0 x 4.0 x 2.5 cm. The cortical surface is pink with flattened gyri. A 2.0 cm area of recent hemorrhage is present on the surface. On section, the gray matter is uniform in thick averaging 0.4 cm. The underlying white matter is uniform with punctate hemorrhages at the deep margin. The cortical hemorrhage is confined to the surface and extends into underlying sulci. Representative sections are submitted in Casaattes (A1)-(A5). MICHOSCOPIC DIAGNOSIS: FRON TAL LOBE (LOBECTOMY): MULTIPLE EARLY ORGANIZING INFARCTS (SEE COMMENT). COMMENT: The findings are similar to those seen in the previous resection I reviewed the diagnostic material; this is my interpretation. Dat + typed: 010899

0955 hours

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Electronically Signed Out By:
M.D.

Page Number:

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PATHOLOGIST

Date of Operative Procedure:

Date received: 010699

Surgical Pathology No.:

CLINICAL HISTORY/OPERATIVE DIAGNOSIS
29 y/o male with re-exploration of craniotomy for cerebral edema.
Source of specimen: Frontal/temporal lobe tissue.

GROSS EXAMINATION:

The specimen, received fresh, labeled with the patient's name and FRONTAL/TEMPORAL LOBE TISSUE, consists of fragments of brain with flattened gyri and sulci measuring in aggregate 15.0 x 10.5 x 2.0 cm. The largest fragment is very friable with multiple discrete collections of clotted blood at the gray-white junction ranging from 3.0 to 0.5 cm. No other discrete lesions are seen. Sections are submitted in cassettes (AI) (A5).

MICROSCOPIC DIAGNOSIS: FRONTAL/TEMPORAL LOBE (RESECTION): MULTIPLE EARLY ORGANIZING INFARCTS (SEE COMMENT).

COMMENT:
The changes seen in this specimen are similar to the previous two specimens and and and the specimens.

I reviewed the diagnostic material; this is my interpretation.

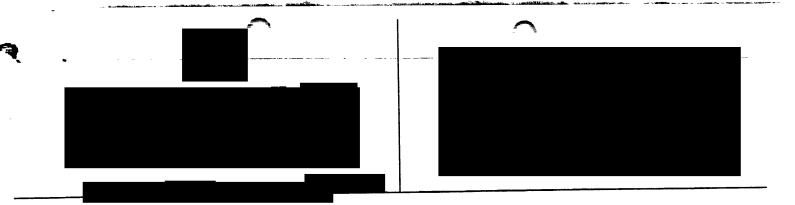
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0855 hours

PATHOLOGIST ELECTRONIC SIGNATURE

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Electronically Signed Out By:



HEMATOLOGY.

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	PROCEDURE	•					
0	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	T	6.0 4.73 14.3 42.0 88.7 30.2 34.0 11.4	8.1 4.35 13.0L 38.0L 87.3 29.9 34.5	.14.1	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]
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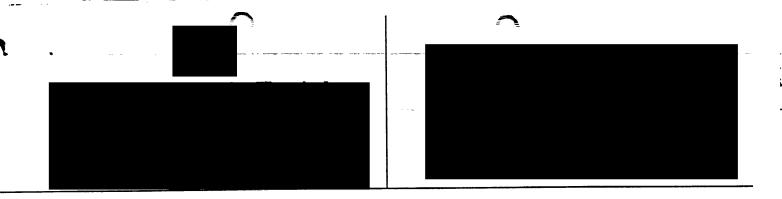
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Legend: L = Low, H = High

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LABORATORY REPORT



HEMATOLOGY ::

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	HGB		13.8	13.3	.14.1	G/DL	[13.2-16.2]
	HCT		40.0	39.1L	· 43.1	8	[40.0-52.0]
	MCV		87.8	88.5	88.7	FL	[82.0-100.0]
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	RDW 1SD		10.7	11.2	11.1	8	[< 14.5]
	PLATELET CO	UNT					
	PLT X 10^3		399	331	383	/uL	[140-440]
	MPV		6.5L	5.9L	6.6L	FL	[6.7-10.2]
	DIFFERENTIAL		,				
	TOTAL NEUT %	•		75.4H		8	[37.0-73.0]
	LYMPH %		-147 A Wa A-	14.7L	en in a service commence of the service servic		[20.0-46.0]
	MONO %	The Marian		7.1		8	[2.0-12.0]
_	EOS %			1.5		8	[0.0-5.0]
	BASO %			1.3		*	[0.0-2.0]
C	TOTL NEUT X10)^3		5.9H		/uL	[2.0-5.0]
	LYMPH # X10^3			1.2L		/uL	[1.3-3.0]
	MONO # X10^3			0.6		/uL	[0.1-1.0]
	EOS # X10^3			0.1		/u <u>L</u>	[0.0-0.3]
	BASO # X10^3			0.1		/uL	[0.0-0.2]

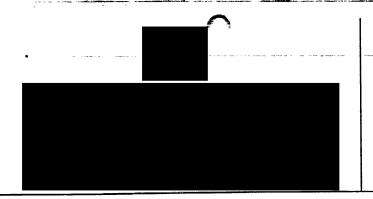
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Legend: L = Low, H = High

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PAGE: 2

LABORATORY REPORT





PRINT DATE/TIME: 01/27/99 0022

HEMATOLOGY

	PROCEDURE	DATE TIME DAY	01/15/99 0200 FRI	01/14/99 0240 THU	01/13/99 0200 WED	UNITS	REFERENCE RANGE
	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	г	8.6 4.58 13.6 40.4 88.1 29.6 33.7 11.3	8.3 4.83 14.3 42.9 88.8 29.6 33.3	10.7 5.07 .14.9 .44.9 88.4 29.5 33.3 11.0	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]
	PLATELET CO PLT X 10^3 MPV	UNT	3 4 6 6.2 L	358 6.3 L	371 6.5 L	/uL FL	[140-440] [6.7-10.2]
9	DIFFERENTIAL TOTAL NEUT % LYMPH % MONO % EOS % BASO % TOTL NEUT X10 LYMPH # X10^3 MONO # X10^3 EOS # X10^3 BASO # X10^3	<u>zs. #≁∞s</u> zo)^3	77.2H 11.8L 7.9 1.6 1.5 6.7H 1.0L 0.7 0.1	74.8H 11.9L 10.9 1.6 0.8 6.2H 1.0L 0.9 0.1	79.4H 8.4L 10.2 1.0 1.0 8.5H .9L 1.1H 0.1	% % % % /uL /uL /uL /uL /uL	[37.0-73.0] [20.0-46.0] [2.0-12.0] [0.0-5.0] [0.0-2.0] [2.0-5.0] [1.3-3.0] [0.1-1.0] [0.0-0.3] [0.0-0.2]

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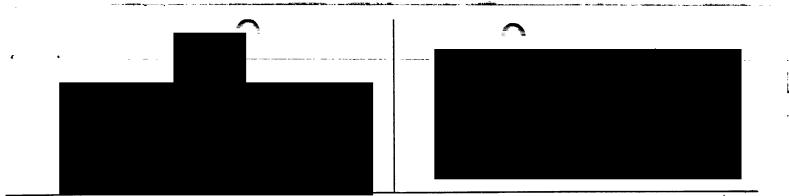
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L = Low, H = High

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PAGE: 3

LABORATORY REPORT



HEMATOLOGY :: ::

	PROCEDURE	DATE TIME DAY	01/12/99 0230 TUE	01/11/99 1405 MON	01/11/99 0829 MON	UNITS	REFERENCE RANGE
•	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	г	9.2 4.94 14.4 43.3 87.6 29.2 33.4 11.0	10.6 4.80 14.1 42.3 88.1 29.4 33.5	.14.1 42.1	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]
	PLATELET CO PLT X 10^3 MPV	UNT	338 6.4 L	300 6.7		/uL FL	[140-440] [6.7-10.2]
9	DIFFERENTIAL TOTAL NEUT % LYMPH % MONO % EOS % BASO % TOTL NEUT X10 LYMPH # X10^3 MONO # X10^3 EOS # X10^3 BASO # X10^3	:::::::::::::::::::::::::::::::::::::	82.7H 9.2L 6.0 1.4 0.7 7.6H .8L 0.6 0.1	86.6H 7.2L 4.1 1.1 1.0 9.2H .8L 0.4 0.1		% % % /uL /uL /uL /uL	[37.0-73.0] [20.0-46.0] [2.0-12.0] [0.0-5.0] [0.0-2.0] [2.0-5.0] [1.3-3.0] [0.1-1.0] [0.0-0.3] [0.0-0.2]

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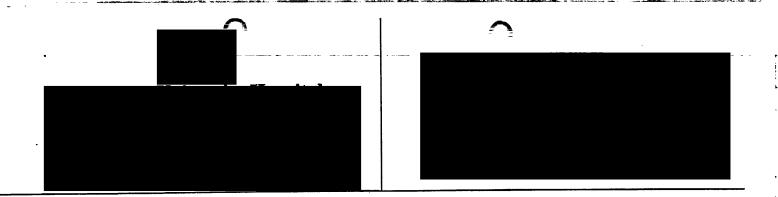
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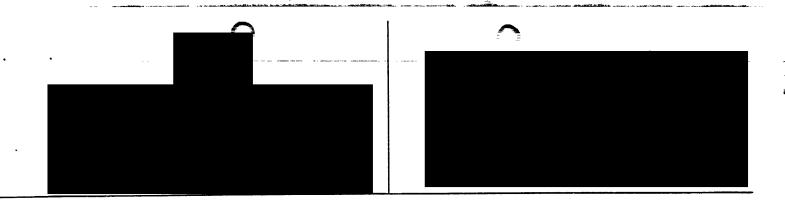
LABORATORY REPORT



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	PROCEDURE	DATE TIME DAY	01/11/99 0135 MON	01/10/99 1435 SUN	01/10/99 0230 SUN	UNITS	REFERENCE I	RANGE
•	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	•	11.9H 4.78 14.0 42.4 88.5 29.4 33.2 11.2	11.8H 4.51 13.5 39.4L 87.3 29.9 34.22	9.6 3.81L .11.3L 33.7L 88.4 29.8 33.7 10.9	/uL /uL G/DL % FL PG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]]] 0]]
	PLATELET COL PLT X 10^3 MPV PLT COMMENT	TNU	303 7.0 LRG PLT*	2 4 5 7.3	202 7.1	/uL FL	[140-440] [6.7-10.2]	
	DIFFERENTIAL TOTAL NEUT % TOTAL NEUT % SEGS % BANDS % LYMPH % MONO % MANUAL EOS % EOS % MANUAL BASO % BASO % MANUAL TOTL NEUT X10 TOTL NEUT X10 LYMPH # X10^3 LYMPH# MANX10 MONO # X10^3 MONO # X10^3 EOS # X10^3 EOS # MAN X10	AN ^3 ^3 ^3	87H 81H 6 8L 4 1 0 10.4H 1.0L 0.5	92.2H 4.6L 1.9L 1.3 0.0' 10.9H .5L 0.2 0.2	87.7H 8.1L 2.1 2.1 0.0 8.4H .8L 0.2 0.2	% % % % % % % % % % % % % % % % % % %	[37.0-73.0 [37-73] [37-73] [0-10] [20.0-46.0 [20-46] [2.0-12.0] [2-12] [0.0-5.0] [0-5] [0.0-2.0] [0-2] [2.0-5.0] [1.3-3.0] [1.3-3.0] [0.1-1.0] [0.1-1.0] [0.0-0.3]	<u> </u>
	Legend: L = Low, H =	High,	* = Abnormal		TED ON NEXT PAG	 E PA	GE: 5	00055

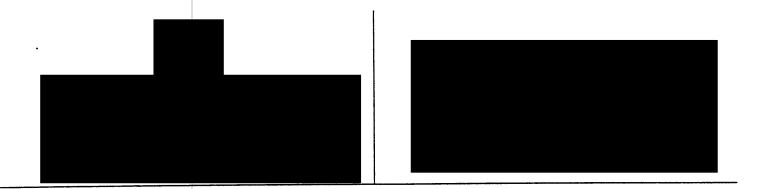
LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



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	PROCEDURE	DATE TIME DAY	01/11/99 0135 MON	01/10/99 1435 SUN	01/10/99 0230 SUN	UNITS	REFERENCE RANGE
	DIFFERENTIAL BASO # X10^3 BASO # MANX10		0.0	0.0	0.0	/uL u/L	[0.0-0.2] [0.0-0.2]
	MORPHOLOGY RBC MORPHOLOG		NORMAL*	مازيد م		- -	
	PROCEDURE	DATE TIME DAY	01/09/99 2215 SAT	01/09/99 1430 SAT	01/09/99 0815 SAT	UNITS	REFERENCE RANGE
	BLOOD COUN WBC X 10^3 RBC X 10^6 HGB HCT		11.5L 34.6L	9.9 3.74L 11.1L 33.1L	10.8L 32.1L	/uL /uL G/DL	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0]
(3)	MCV MCH MCHC RDW 1SD	<u> </u>	······································	29.7 33.6 11.1		pG G/DL %	[82.0-100_0]
	PLATELET CO PLT X 10^3 MPV	UNT		179 7.2 _,		/uL FL	[140-440] [6.7-10.2]
	DIFFERENTIAL TOTAL NEUT % LYMPH %	-	A CONTROL OF STREET	82.5H 10.7L		8 8	[37.0-73.0] [20.0-46.0]
	MONO % EOS % BASO % TOTL NEUT X10 LYMPH # X10^3			2.3 0.2 8.2H 1.1L		% % /uL /uL	[0.0-5.0] [0.0-2.0] [2.0-5.0] [1.3-3.0]
	Legend: L = Low, H =	High,	* = Abnormal		ed on next pa	GE PAG	000056 SE: 6

LABORATORY REPORT



			Carrier Carrie		HEMATOLOG	CY, RESPUBLI		
	PROCEDURE	DATE TIME DAY	01/09/99 2215 SAT	01/09/99 1430 SAT	01/09/99 0815 SAT	UNITS	REFERENCE RANGE	
•	DIFFERENTIAL MONO # X10^3 EOS # X10^3 BASO # X10^3			0.4 0.2 0.0		/uL /uL /uL	[0.1-1.0] [0.0-0.3] [0.0-0.2]	
	PROCEDURE	DATE TIME DAY	01/09/99 0230 SAT	01/08/99 2030 FRI	01/08/99 1330 FRI	- UNITS	REFERENCE RANGE	
	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC		9.6 3.65L 10.8L 32.0L 87.6 29.6 33.7	9.8L 28.8L	7.8 3.11L 9.3L 27.4L 88.1 29.9 33.9	/uL /uL G/DL % FL pG G/DL	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1]	
)	PLATELET COUPLT X 10^3 MPV	UNT	159 7.3		139L 7.4	/uL FL	[140-440] [6.7-10.2]	
	DIFFERENTIAL TOTAL NEUT % LYMPH % MONO % EOS % BASO % TOTL NEUT X10 LYMPH # X10^3 MONO # X10^3 EOS # X10^3 BASO # X10^3	·^3	86.3H 6.6L 4.9 1.7 0.5 8.3H .6L 0.5 0.2	,	82.1H 10.2L 4.9 2.4 1.4 6.4H .8L 0.4 0.2	% % % % % /uL /uL /uL /uL	[37.0-73.0] [20.0-46.0] [2.0-12.0] [0.0-5.0] [0.0-2.0] [2.0-5.0] [1.3-3.0] [0.1-1.0] [0.0-0.3] [0.0-0.2]	

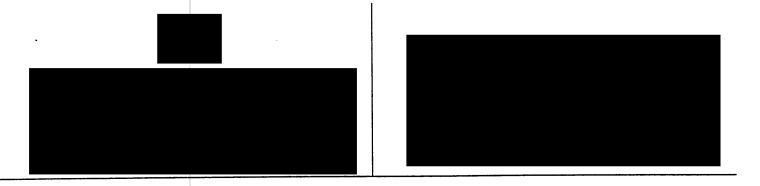
LABORATORY REPORT

Legend:

L = Low, H = High

DISCHARGE - FINAL MEDICAL RECORDS

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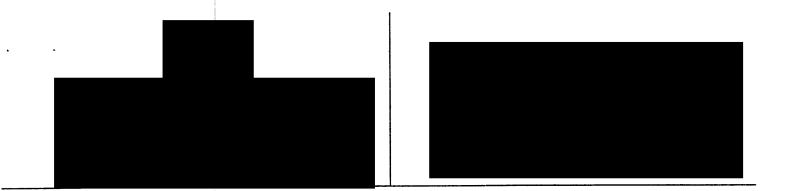
01/08/99 01/08/99 DATE 01/09/99 1330 2030 0230 TIME FRI FRI DAY SAT UNITS REFERENCE RANGE **PROCEDURE** MORPHOLOGY NORMAL * RBC MORPHOLOGY 01/08/99 01/07/99 01/08/99 DATE . 1400 0330 TIME 0840 FRI DAY UNITS REFERENCE RANGE PROCEDURE م وسريكي **BLOOD COUNT** [4.1-10.9]/uL 9.0 8.1 WBC X 10^3 [4.30-5.90]2.83L /uL 3.18L RBC X 10^6 G/DL [13.2-16.2] 8.8L 9.4L 8.2L **HGB** [40.0-52.0] 24.7L 용 26.4L 28.0L HCT FL[82.0-100.0] 87.0 MCV 88.0 29.0 [26.5-34.0] 29.5 рG MCH [31.8-35.1] 33.5 33.4 G/DL MCHC 14.5] [< 11.4 11.4 RDW 1SD PLATELET COUNT [140-440] PLT X 10^3 160 151 /uL [6.7-10.2]FL7.4 MPV 7.4 DIFFERENTIAL [37.0-73.0] 85.6H 86.0H 윰 TOTAL NEUT % 7.7L 5.4L ક્ર [20.0-46.0] LYMPH % [2.0-12.0] 7.7 윰 5.3 MONO & [0.0-5.0]0.9 0.6 윰 EOS € [0.0-2.0]0.3 ₽ 0.5 BASO % [2.0-5.0]7.7H 7.1H /uL TOTL NEUT X10^3 [1.3-3.0] .7L .4L /uL LYMPH # X10^3. [0.1-1.0] 0.5 0.6 **7uL** MONO # X10^3 [0.0-0.3] /uL EOS # X10^3 0.1 0.0 /uL [0.0-0.2]BASO # X10^3 0.0 0.0

Legend:

L = Low, H = High, * = Abnormal

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HEMATOLOGY

		DATE TIME DAY	01/07/99 0800 THU	01/07/99 0200 THU	01/06/99 2150 WED	, name	DESERVATE DANGE	
	PROCEDURE					UNITS	REFERENCE RANGE	
9	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	Γ	8.3 3.08L 9.1L 26.7L 86.8 29.5 33.9 11.0	9.3 3.34L 9.7L 29.3L 87.6 29.2 33.3 11.6	10.4 3.69L .10.9L .32.1L 86.9 29.5 33.9 10.9	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]	
	PLATELET CO PLT X 10^3 MPV	UNT	161 7.5	174 7.3	190 7.5	/uL FL	[140-440] [6.7-10.2]	
	PROCEDURE	DATE TIME DAY	01/06/99 1745 WED	01/06/99 1400 WED	01/06/99 0200 WED	UNITS	REFERENCE RANGE	. .
•	BLOOD COUN WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	т	5.0 3.95L 11.5L 34.5L 87.3 29.2 33.4 11.2	9.1L 26.9L	9.6 3.44L 10.4L 30.2L 87.7 30.2 34.4 11.0	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]	
	PLATELET CO PLT X 10^3 MPV	UNT	166 7.0	153	175 7.1	/uL FL	[140-440] [6.7-10.2]	

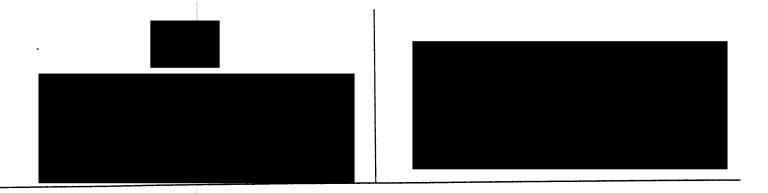
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Legend: L = Low

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LABORATORY REPORT



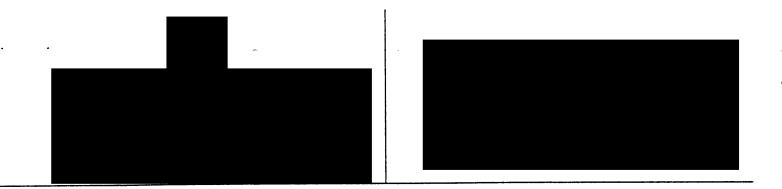
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	PROCEDURE	DATE TIME DAY	01/06/99 1745 WED	01/06/99 1400 WED	01/06/99 0200 WED	UNITS	REFERENCE RANGE
	DIFFERENTIAL TOTAL NEUT* M SEGS % BANDS % LYMPH % MANUAL MONO % MANUAL EOS % MANUAL TOTL NEUT X10 LYMPH# MANX10 MONO # MANX10 EOS # MAN X10 BASO # MANX10	IAN L		۳ رسر می _ن و	87H 82H 5 7L 4 1	% % % % u/L u/L u/L	[37-73] [37-73] [0-10] [20-46] [2-12] [0-5] [0-2]
	MORPHOLOGY RBC MORPHOLOG				NORMAL*		
	we see t			01/05/99 	01/04/99 	treature	<u> </u>
9	PROCEDURE	DAY	TUE		MON	UNITS	REFERENCE RANGE
	BLOOD COUN WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	T	9.2 3.65L 10.9L 32.3L 88.4 30.0 33.9 10.9	11.8H 4.42 13.4, 38.7L 87.4 30.3 34.6 10.6	4.10L 12.3L 35.7L 86.8 30.0 34.5 10.6	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]
	PLATELET CO PLT X 10^3 MPV	TNUC	173 7.5	219 7.2		/uL FL	[140-440] [6.7-10.2]
	Legend: L = Low, H =	High,	* = Abnormal	CONTINU	ED ON NEXT PAG	g PA	000060 GE: 10



HEMATOLOGY

	PROCEDURE	DATE TIME DAY	01/05/99 1000 TUE	01/05/99 0215 TUE	01/04/99 1920 MON	UNITS	REFERENCE RANGE
•	DIFFERENTIAL TOTAL NEUT % LYMPH % MONO % EOS % BASO % TOTL NEUT X10- LYMPH # X10-3 MONO # X10-3 EOS # X10-3 BASO # X10-3	^3		85.9H 5.6L 8.1 0.1 0.3 10.1H 29L 1.0 0.0 0.0		% % % % % /uL /uL /uL /uL	[37.0-73.0] [20.0-46.0] [2.0-12.0] [0.0-5.0] [0.0-2.0] [2.0-5.0] [1.3-3.0] [0.1-1.0] [0.0-0.3] [0.0-0.2]
	PROCEDURE	DATE TIME DAY	01/04/99 0820 MON	01/04/99 0240 MON	01/03/99 0040 SUN	UNITS	REFERENCE RANGE
	BLOOD COUNT	Γ					
	WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD		7.6 4.19L 12.4L 37.2L 88.7 29.5 33.2 10.6	10.1 5.04 14.7 44.2 87.7 29.2 33.3 10.5	8.9 5.07 15.1 44.6 87.9 29.8 33.9 10.4	/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]
	PLATELET COU PLT X 10^3 MPV	UNT	189	246 6.8	237 6.9	/uL FL	[140-440] [6.7-10.2]
	DIFFERENTIAL TOTAL NEUT % TOTAL NEUT% M SEGS %		74-4H	81 H 76 H		& &	[37.0-73.0] [37-73] [37-73]
	Legend: L = Low, H =	High		CONTINUI	ED ON NEXT PA	AGE PAG	9E: 11 000061



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	PROCEDURE	DATE TIME DAY	01/04/99 0820 MON	01/04/99 0240 MON	01/03/99 0040 SUN	UNITS	REFERENCE RANGE
	DIFFERENTIAL						
	BANDS %			5		8	[0-10]
}	LYMPH %		18.9 L			€	[20.0-46.0]
	LYMPH % MANUA	L		11 L		8	[20-46]
	MONO &		5.6		·•	€	[2.0-12.0]
	MONO % MANUAL	1		8		& & & &	[2-12]
	EOS %		0.5			<u>_</u> &	[0.0-5.0]
	EOS % MANUAL			. . -0		~ &	[0-5]
	BASO %		0.6			ક ક	[0.0-2.0]
	BASO % MANUAL	ı		0			[0-2]
	TOTL NEUT X10	^3	5.8H			/uL	[2.0-5.0]
	TOTL NEUT X10	1^3		8.2H		\mathtt{u}/\mathtt{L}	[2.0-5.0]
	LYMPH # X10^3		1.4			/uL	[1.3-3.0]
	LYMPH# MANx10			1.1L		\mathtt{u}/\mathtt{L}	[1.3-3.0]
	MONO # X10^3		0.4			/uL	[0.1-1.0]
	MONO # MANX10	^3		0.8		\mathtt{u}/\mathtt{L}	[0.1-1.0]
	EOS # X10^3		0.0			/uL	
	EOS # MAN X10	^3		0.0		u/L	
	BASO # X10^3		0.0			/uL	[0.0-0.2]
	BASO # MANX10)^3	and the second all the	0.0	The second secon	······································	[0.0-0.2]

MORPHOLOGY RBC MORPHOLOGY

NORMAL*

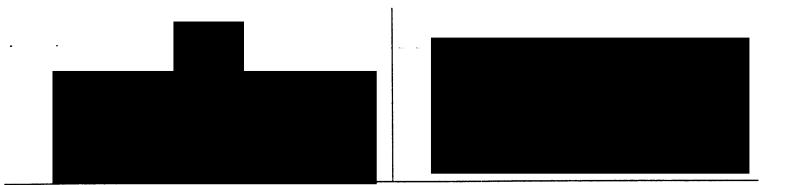
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L = Low, H = High, * = Abnormal

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PROCEDURE	DATE TIME DAY	01/01/99 2201 FRI	12/30/98 1825 WED		UNITS	REFERENCE RANGE
BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB HCT MCV MCH MCHC RDW 1SD	Т	8.9 5.12 15.2 44.8 87.4 29.6 33.8 10.3	11.5H 5.14 15.1 45.1 87.6 29.5 33.6		/uL /uL G/DL % FL pG G/DL %	[4.1-10.9] [4.30-5.90] [13.2-16.2] [40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]
PLATELET CO PLT X 10^3 MPV DIFFERENTIAL TOTAL NEUT % LYMPH % MONO % EOS % BASO % TOTL NEUT X10 LYMPH # X10^3 MONO # X10^3 EOS # X10^3 BASO # X10^3 MISCELLANEO	- 		231 7.0 87.7H 8.2L 3.8 0.1 0.2 10.2H .9L 0.4 0.0	it is a a description and a same of the confidence of the confid	/uL % % % % /uL /uL /uL /uL	[140-440] [6.7-10.2] [37.0-73.0] [20.0-46.0] [2.0-12.0] [0.0-5.0] [0.0-2.0] [2.0-5.0] [1.3-3.0] [0.1-1.0] [0.0-0.3] [0.0-0.2]
MISCELLANEO SED RATE	DUS HEN	MATOLOGY	3		MM/HR	[0-15]

000063

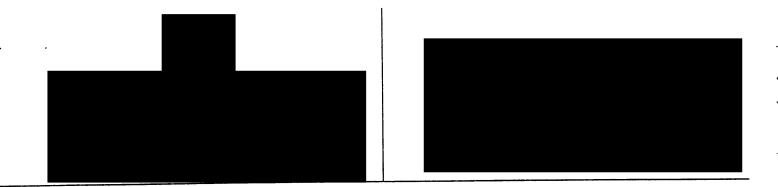
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L = Low, H = High

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LABORATORY REPORT



ANEMIA TESTS

DATE 01/05/99 1000 TIME

DAY TUE PROCEDURE

[211-911] PG/ML 295 VITAMIN B12

COAGULATION

01/25/99 01/24/99 01/26/99 DATE 0450 0430 0504 TIME MON SUN DAY TUE

UNITS REFERENCE RANGE PROCEDURE

ROUTINE COAGULATION

[10.5-12.8] 17.1H SEC 16.7H 17.3H PROTIME

(12/02/98 -- Current) A new Protime reagent is in use as of 12/03/98. It is more sensitive with an ISI of 1.02. Protime results in seconds may be

longer, but there is no change in therapeutic INR (2.0 - 3.0).

INR 1.5 1.4 1.5 INR

(06/16/97 -- Current) THE INR (INTERNATIONAL NORMALIZED RATIO) IS INTENDED FOR PATIENTS ON STABLE LONG TERM ORAL ANTICOAGULANT THERAPY. INR VALUES SHOULD APPROXIMATE 2.0 TO 3.0 IN MOST CASES, AND 2.5 TO 3.5 FOR HIGHER INTENSITY OF

ANTICOAGULATION. [22.0-35.0] 61.5H 60.8H SEC 70.3H

(03/26/98 -- Current) THERAPEUTIC RANGE FOR UNFRACTIONATED HEPARIN: 40 - 80 seconds

000064

REFERENCE RANGE

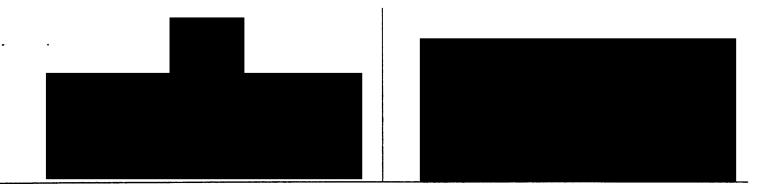
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LABORATORY REPORT



COAGULATION :

PROCEDURE	DATE TIME DAY	01/23/99 0444 SAT	01/22/99 1200 FRI	01/22/99 0530 FRI	UNITS	REFERENCE RANGE				
ROUTINE COA	GULATI	ON								
PROTIME INR PTT	6 mar	17.1H 1.5 56.6H	14.8H 1.3 52.3H	14.6H 1.3 .49.1H	SEC INR SEC	[10.5-12.8]				
PROCEDURE	DATE TIME DAY	01/21/99 2350 THU	01/21/99 1840 THU	01/21/99 1130 THU	- UNITS	REFERENCE RANGE				
ROUTINE COA	ROUTINE COAGULATION									
PROTIME		13.6H	13.3H	14.2H	SEC	[10.5-12.8]				
INR PTT		1.2 47.2 H	1.1 45.1 H	1.2 45.2 H	INR SEC	[22.0-35.0]				
PROCEDURE	DATE TIME DAY	01/21/99 0425 THU	01/20/99 2400 WED	01/20/99 1815 WED	UNITS	REFERENCE_RANGE				
PROTINE COA	AGULAII	13.9H	14.2 H	14.3 H	SEC	[10.5-12.8]				
INR PTT		1.2 48.7 H	1.2 53.0 H	1.2 58.7 H	INR SEC	[22.0-35.0]				

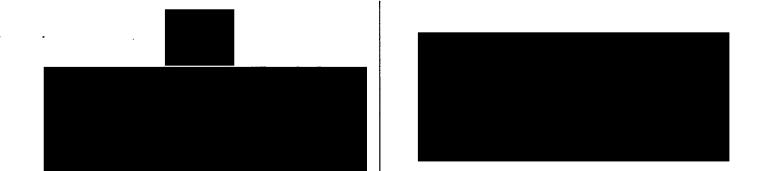
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LABORATORY REPORT



COAGULATION COAGULATION

PROCEDURE	DATE TIME DAY	01/20/99 1204 WED	01/20/99 0430 WED	01/19/99 2355 TUE	UNITS	REFERENCE RANGE					
ROUTINE COA	ROUTINE COAGULATION										
PROTIME		14.1H	13.8H	13.8H	SEC	[10.5-12.8]					
INR PTT		1.2 59.4 H	1.2 36.5 H	1.2 , 37.3 H	INR SEC	[22.0-35.0]					
e e y management grippe en e				. •	Agents to the same of the same	•					
	DATE TIME	01/19/99 2210	01/19/99 1425	01/18/99 1412							
	DAY	TUE	TUE	MON	-						
PROCEDURE					UNITS	REFERENCE RANGE					
ROUTINE COA	GIII AT	ion									
PROTIME COA	GOLAI	IOI	13.6H	13.4H	SEC	[10.5-12.8]					
INR			1.2	1.2	INR	100 0 35 03					
PTT		39.0H	22.2	22.7	SEC	[22.0-35.0]					
	DATE	01/17/99	01/16/99	01/15/99							
	TIME DAY	1430 SUN	0220 SAT	1123 FRI							
PROCEDURE	DAI				UNITS	REFERENCE_RANGE					
						-					
ROUTINE COA	GULAT	ION									
PROTIME		12.8	12.5 1.1	12.4 1.1	SEC INR	[10.5-12.8]					
INR PTT		1.1 21.0 L	22.6	20.6L	SEC	[22.0-35.0]					

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Legend:

L = Low, H = High

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LABORATORY REPORT





COAGULATION

PROCEDURE	DATE TIME DAY	01/15/99 0200 FRI	01/14/99 0240 THU	01/13/99 0200 WED	UNITS	REFERENCE RANGE					
POLITINE COA	ROUTINE COAGULATION										
PROTIME INR PTT		12.4 1.1 22.7	11.9 1.0 24.0	12.2 1.0 .23.4	SEC INR SEC	[10.5-12.8] [22.0-35.0]					
PROCEDURE	DATE TIME DAY	01/12/99 0230 TUE	01/11/99 0830 MON	01/11/99 0645 MON	- UNITS	REFERENCE RANGE					
ROUTINE COA	GULATI	ION									
PROTIME		12.4	12.4	12.6	SEC	[10.5-12.8]					
INR PTT		1.1 23.2	1.1 23.4	1.1 23.0	INR SEC	[22.0-35.0]					
PROCEDURE	DATE TIME DAY	01/10/99 1435 SUN	01/10/99 0230 SUN	01/09/99 2215 SAT	UNITS	REFERENCE <u></u> RANGE					
ROUTINE COA PROTIME INR PTT	GULAT	12.6 1.1	12.8 1.1 20.6 L	12.5 1.1 20.6 L	SEC INR SEC	[10.5-12.8] [22.0-35.0]					

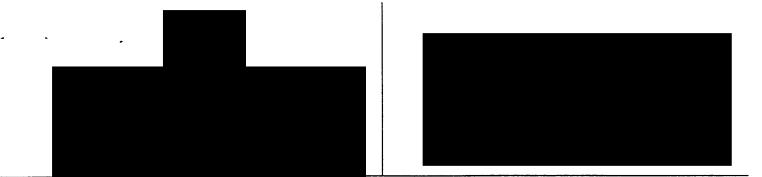
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Legend: L = Low

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LABORATORY REPORT



	COAGULATION SHOW
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PROCEDURE	DATE TIME DAY	01/09/99 1430 SAT	01/09/99 0815 SAT	01/09/99 0200 SAT		UNITS	REFERENCE RANGE
ROUTINE COAC	SIII ATI	ON					
PROTIME INR PTT	30LA11	12.8 1.1 22.4	12.3 1.1 20.8L	12.4 1.1 .19.9L		SEC INR SEC	[10.5-12.8]
PROCEDURE	DATE TIME DAY	01/08/99 2030 FRI	01/08/99 1635 FRI	01/08/99 1330 FRI		- UNITS	REFERENCE RANGE
ROUTINE COAC PROTIME INR PTT 01/08/99		12.6 1.1 20.9L CALLED TO	11.8 1.0 17.8 L	12.2 1.0 16.9 Lf AT 01/08/99	16:31 .	SEC INR SEC	[10.5-12.8] [22.0-35.0]
PROCEDURE	DATE TIME DAY	01/08/99 0840 FRI	01/08/99 0330 FRI	01/07/99 1940 THU		UNITS	REFERENCE RANGE
ROUTINE COAC PROTIME INR PTT PTT 01/07/9		12.8 1.1 19.3 L	13.0 H 1.1 19.2 L ESULTS CALI	11.4 1.0 >100 SECCF WED TO		SEC INR SEC SEC	[10.5-12.8] [22.0-35.0] [22 - 35] /99 20:44;

000068

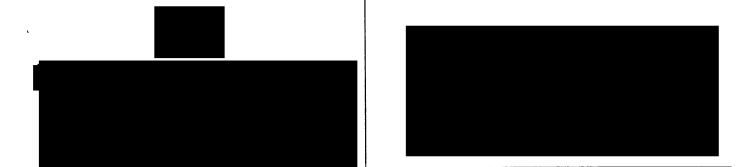
Legend:

L = Low, H = High, C = Critical, f = Footnote

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LABORATORY REPORT



CO/AGUL/ATION

DAT TIM DA PROCEDURE	E 1400	01/07/99 0800 THU	01/07/99 0200 THU	UNITS	REFERENCE RANGE
ROUTINE COAGULA	ATION 12.6	13.9H	13.6 H	SEC	[10.5-12.8]
INR PTT	1.1 19.4L	1.2 20.1 L	1.2 .21.8L	INR SEC	[22.0-35.0]
DAT TIM DA	E 2150	01/06/99 1745 WEDF	01/06/99 1400 WED	4.	REFERENCE RANGE
PROCEDURE	A TIONI			UNITS	REFERENCE RANGE
ROUTINE COAGULATHROMBIN TIME PROTIME	14.1H	17.5 13.7 H	13.6 H	SEC SEC	[14.0-18.0] [10.5-12.8]
INR PTT FIBRINOGEN	1.2 24.3	1.2 23.4 300.0	1.2 23.2 468.0Hf	INR SEC MG/DL	[22.0-35.0] [150.0-400.0]
01/06/99 14 D-DIMER BLEEDING TIME	00 CALLED TO	BY 1.0-2.0* 5.0	01/06/99 14:41	MINUTE	[<0.5] [2.0-9.0]=

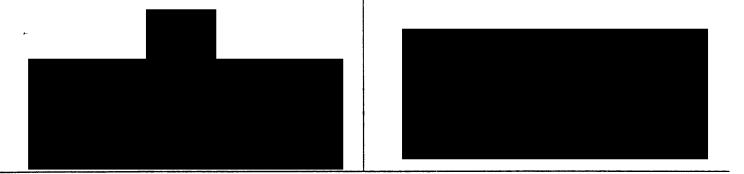
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Legend:

L = Low, H = High, * = Abnormal, f = Footnote

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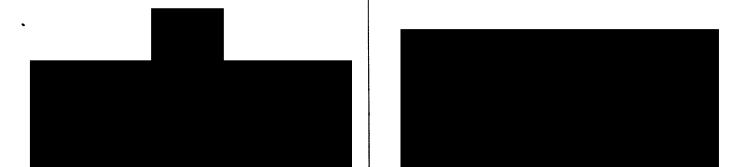


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	PROCEDURE	DATE TIME DAY	01/06/99 0200 WED	01/05/99 1900 TUE	01/05/99 1115 	UNITS	REFERENCE RANGE
0	ROUTINE COA PROTIME INR PTT		13.8 H 1.2 22.5	13.5H 1.2 23.0	,30.0	SEC INR SEC	[10.5-12.8] [22.0-35.0]
	PROCEDURE	DATE TIME DAY	01/05/99 1000 TUE	01/05/99 0730 TUE	01/05/99 0215 TUE	UNITS	REFERENCE RANGE
	ROUTINE COA		ON 13.4H REPORT CAI	14.4Hf	13.5 H IN OR AT 0750/	SEC	[10.5-12.8]
	INR PTT		1.2	1.2 24.5	1.2 19.6 L	INR SEC	[22.0-35.0]
	PROCEDURE	DATE TIME DAY	01/05/99 0041 	. 01/04/99 1920 MON	01/04/99 1715 MON	UNITS	REFERENCE RANGE
	ROUTINE COA THROMBIN TIME PROTIME INR PTT FIBRINOGEN		ON 13.7H 1.2 25.1	15.2 , 355.0	14.1 H 1.2 26.6	SEC SEC INR SEC MG/DL	[14.0-18.0] [10.5-12.8] [22.0-35.0] [150.0-400.0]
	SPECIAL COA PROTEIN C ACT DVVT DVVT CONFIRM PLT NEUTRALIZ PROTEIN C RES	riv Z.		97 41.3 H 0.98 POSITIVE * 2.36		% SECS SECS SECS	[82-165] [< 38.0] [< 1.09] [NEGATIVE] [> 1.93]
	Legend: L = Low, H =	High,	* = Abnorma	•	note		000070

LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS

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(03/24/97 -- Current)

RESEARCH ONLY. NOT FOR DIAGNOSTIC USE.

DD COEDUDE	DATE TIME DAY	01/04/99 0820 MON	01/04/99 0415 MON	01/04/99 0240 MON	UNITS	REFERENCE RANGE
PROCEDURE					011115	TELL MEMORIAL TOTAL COLUMN
ROUTINE COA	GULATI	ON		•		
PROTIME	نىدادى دا نىڭد ىمۇس			₹12.8	SEC	[10.5-12.8]
INR		1.1		1.1	INR	
PTT		26.7	30.6	38.1H	_ SEC	[22.0-35.0]
	DATE	01/03/99	01/02/99	01/01/99		
	TIME	0040	0355	2201		
	DAY	SUN	SAT	FRI		
PROCEDURE	DAI				UNITS	REFERENCE RANGE
ROUTINE COA	GULAT	ION				
PROTIME		12.7	13.0H	12.6	SEC	[10.5-12.8]
INR		1.1	1.1	1.1	INR	
PTT		44.5 H	46.7 H	43.9 H	SEC	[22.0-35.0]

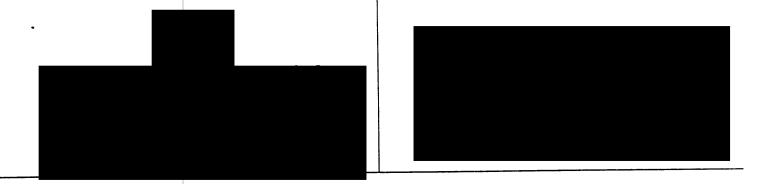
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LABORATORY REPORT



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DATE TIME DAY PROCEDURE		12/31/98 1140 THU	12/31/98 0200 THU	UNITS	REFERENCE RANGE
ROUTINE COAGULA PROTIME INR PTT	TION 52.2H	56.8 H	13.2H 1.1 .47.3H	SEC INR SEC	[10.5-12.8]
DATE TIME DAY PROCEDURE	12/30/98 1825		•	- UNITS	REFERENCE RANGE
ROUTINE COAGULA PROTIME INR PTT	13.1H 1.1 43.8H			SEC INR SEC	[10.5-12.8] [22.0-35.0]

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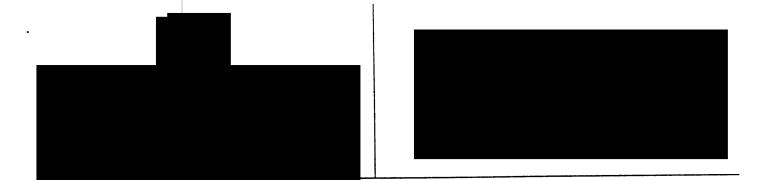
DATE TIME DAY PROCEDURE	01/17/99 1130 SUN	01/16/99 1000 SAT	UNITS	REFERENCE RANGE
MACROSCOPIC COLOR APPEARANCE	YELLOW CLEAR	YELLOW CLEAR	·	[CLEAR]

BILIRUBIN	NEGATIVE	NEGATIVE	[NEGATIVE]
	NEGATIVE	NEGATIVE	[NEGATIVE]
	NEGATIVE	NEGATIVE	[NEGATIVE]
	1.025	>=1.030*	[SG REF]

000072 Legend: H = High, * = Abnormal PAGE: 22

DISCHARGE - FINAL MEDICAL RECORDS LABORATORY REPORT

CONTINUED ON NEXT PAGE



DATE TIME DAY 01/22/99 1100 FRI 01/17/99 1130 SUN 01/16/99 1000 SAT

PROCEDURE

UNITS REFERENCE RANGE

BLOO

CHEM STRIP [NEGATIVE] LARGE* MODERATE* BLOOD 5.0 [4.5-8.0]PH [4.5-7.8]6.5 PH [NEGATIVE] TRACE* TRACE* PROTEIN [0.2-1.0]0.2 0.2 UROBILINOGEN [NEGATIVE] NEGATIVE NEGATIVE NITRATE [NEGATIVE] NEGATIVE' NEGATIVE LEUKO ESTERASE

MICROSCOPIC

[0-2 / LPF]NONE NONE SQUAMOUS EPITH [0-4/HPF]0 - 40 - 4WBC/HPF [0-3]10-25* 25-50* RBC/HPF [NEGATIVE] 1 +* BACTERIA SLIGHT MUCUS [0-4 HYAL] 0 - 4HYALINE CAST

URINE CHEMISTRY

SODIUM, URINE R 55
OSMOLALITY, UR 358
MEQ/L
MOSM/K [300-900]

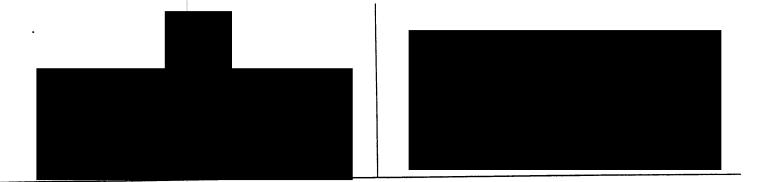
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* = Abnormal

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LABORATORY REPORT



TO THE PROPERTY OF THE PROPERT

DATE TIME DAY 01/14/99 1000 THU

PROCEDURE

UNITS

REFERENCE RANGE

MACROSCOPIC

COLOR APPEARANCE YELLOW CLEAR

[CLEAR]

CHEM STRIP

GLUCOSE BILIRUBIN KETONES SPEC GRAVITY BLOOD PH PROTEIN UROBILINOGEN NITRATE LEUKO ESTERASE

MICROSCOPIC

RBC/HPF

MUCUS

BACTERIA

SQUAMOUS EPITH

NEGATIVE NEGATIVE NEGATIVE >=1.030* LARGE* 5.0

30* 0.2 NEGATIVE NEGATIVE

SLIGHT

0 - 20 - 425-50* NEGATIVE

[NEGATIVE] [NEGATIVE] [NEGATIVE] [SG REF] [NEGATIVE] [4.5-8.0][NEGATIVE] [0.2-1.0][NEGATIVE] [NEGATIVE]

[0-2 /LPF1 [0-4 /HPF] [0-3]

[NEGATIVE]

WBC/HPF

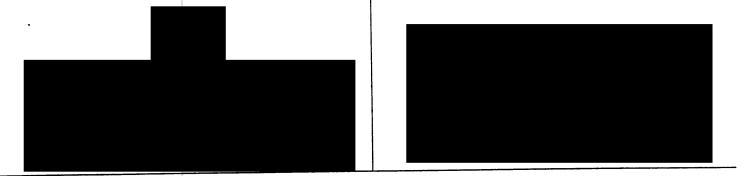
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LABORATORY REPORT



NUTRATORIE VILLE DE COMEDURES

			INTRAUPE	HATIVE	JUEDUNES	
	DATE TIME DAY PROCEDURE	01/06/99 1620 WED	01/06/99 1612 WED	01/06/99 1543 WED	UNITS	REFERENCE RANGE
	PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS HEMOGLOBIN O2 SAT	7.34L 49.9H 79 26.5H 0.2 12.3L 94.9L	7.33L 45.6H 85 23.2 -2.8L 11.8L 95.7	7.39 42.3 45L .24.9 	MMHG MMHG MMOL/L * MMOL/L G/DL 2 % MMOL/L	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [13.2-16.2] [95.0-98.0] [137-145]
	SODIUM POTASSIUM 01/06/99 1612	143 3.3L CRITICAL RI	145H 2.8Cf ESULTS REPOR	4.1	MMOL/L	[3.6-5.0]
	IONIZED CALCIUM CHLORIDE GLUCOSE	3.9L 113H 163H	3.2L 116H 154H	4.4L 110H 162H	MG/DL MMOL/L MG/DL	[4.7-5.1] [98-107] [65-105]
	DATE TIME DAY PROCEDURE	01/06/99 1502 WED	01/06/99 1404 WED	01/06/99 1302 	UNITS	REFERENCE RANGE
•	PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS HEMOGLOBIN O2 SAT SODIUM POTASSIUM IONIZED CALCIUM CHLORIDE GLUCOSE	7.49H 35.0 80 26.1H 2.8H 9.7L 96.7 143 3.5L 3.8L 112H 135H	7.47H 36.1 92 25.7 2.1 9.6L 97.5, 143 3.8 4.0L 110H 142H	7.49H 32.9L 314H 24.6 1.6 10.8L 99.8H 143 3.5L 4.3L 114H	MMHG MMHG MMOL/L MMOL/L G/DL % MMOL/L MMOL/L MG/DL MMOL/L MG/DL	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [13.2-16.2] [95.0-98.0] [137-145] [3.6-5.0] [4.7-5.1] [98-107] [65-105]

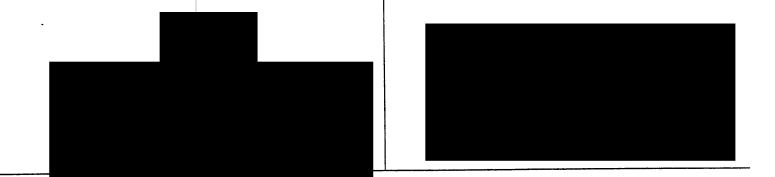
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L = Low, H = High, C = Critical, f = Footnote

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LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



			INTRAOPE	ERATIVEPHO	UCEDURES	

	DATE TIME DAY PROCEDURE	01/05/99 0915 TUE	01/05/99 0724 TUE	01/04/99 0725 MON	UNITS	REFERENCE RANGE
	PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS HEMOGLOBIN O2 SAT SODIUM POTASSIUM IONIZED CALCIUM CHLORIDE GLUCOSE	7.49H 37.1 113H 27.7H 4.3H 10.9L 98.4H 143 3.3L 3.9L 109H 131H	7.51H 33.8L 125H 26.4H 3.6H 11.8L 98.8H 145 3.2L 4.2L 107 129H	7.47H 38.1 94 .27.0H .3.2H 12.3L 97.6 137 3.7 4.1L 106 107H	MMHG MMHG MMOL/L MMOL/L G/DL % MMOL/L MMOL/L MG/DL MMOL/L MG/DL MG/DL	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [13.2-16.2] [95.0-98.0] [137-145] [3.6-5.0] [4.7-5.1] [98-107] [65-105]
	DATE TIME DAY PROCEDURE	01/04/99 0442 MON			UNITS	REFERENCE RANGE
)	PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS HEMOGLOBIN O2 SAT SODIUM POTASSIUM 01/04/99 0442	7.48H 27.0L 214H 19.7L -2.7L 11.3L 99.5H 146H 2.7Cf CRITICAL R	ESULTS RÉPO	RTED TO	MMHG MMHG MMOL/L MMOL/L G/DL % MMOL/L MMOL/L	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [13.2-16.2] [95.0-98.0] [137-145] [3.6-5.0]
	IONIZED CALCIUM CHLORIDE GLUCOSE	2.7 L 109 H 79			MG/DL MMOL/L MG/DL	[4.7-5.1] [98-107] [65-105]

Legend:

L = Low, H = High, C = Critical, f = Footnote

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LABORATORY REPORT



PROCEDURE	DATE TIME DAY	01/10/99 1435 SUN	01/10/99 0940 SUN	01/10/99 0230 SUN	τ	UNITS	REFERENCE RANGE
PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2	- Beneral	7.44 38.1 62L 25.2 1.2 92.6L	7.41 37.8 84 23.6 7 96.5	7.50H 32.9L 95 24.9 2.1 97.8	ana lan qa qa jarkey da maray — —]	MMHG MMHG MMOL/L MMOL/L %	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0]
PROCEDURE	DATE TIME DAY	01/09/99 1430 SAT	01/09/99 0500 SAT	01/09/99 0230 SAT		UNITS	REFERENCE RANGE
PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2 PT TEMP CORR PH CORR PCO2 CORR PCO2 MODE ABG VT ABG VENT RATE PEEP ABG PRESSURE SUPI		7.52H 33.7L 79 26.7H 4.0H 96.8 50 38.0H 7.50 35.2 85 SIMV 1000 10 8 10 YES	7.48H 34.2L 82 24.9 1.7 96.8	7.46H 36.4 58L 25.5 1.8 94.5L		MMHG MMHG MMOL/L MMOL/L % mmHG mmHG MML BPM CMH20	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0] [37.0-37.0]

Legend: L = Low, H = High

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LABORATORY REPORT



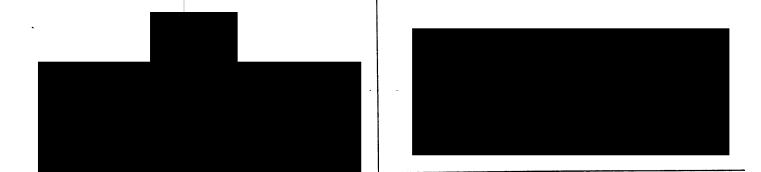
PROCEDURE	DATE TIME DAY	01/08/99 1825 FRI	01/08/99 1330 FRI	01/08/99 1040 FRI	UNITS	REFERENCE RANGE
PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2 PT TEMP CORR PH CORR PCO2 CORR PO2 MODE ABG VT ABG VENT RATE PEEP ABG PRESSURE SUPP SPONTANEOUS IS SPONTANEOUS IS SPONTANEOUS IS CPR ARTERIAL LINE	RR VT	7.50H 33.5L 67L 25.2 2.2 94.9L .50 38.8H 7.47 36.2 76 SIMV 01 10 5 10 04 530 NO YES	7.44 39.3 68L 26.3H 2.1 94.3L	0.8	MMHG MMHG MMOL/L MMOL/L % mmHG mmHG ML BPM CMH20 BPM	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0] [37.0-37.0]

Legend: L = Low, H = High

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LABORATORY REPORT



BEOOD GASES

	PROCEDURE	DATE TIME DAY	01/08/99 0840 FRI	01/08/99 0330 FRI	01/07/99 1830 THU	UNITS	REFERENCE RANGE
)	PH ARTERIAL PCO2 PO2 ARTERIAL		7.49H 34.3L 74L	7.48 H 35.7 75	7.49H 34.3L . 103H	MMHG MMHG	[7.35-7.45] [35.0-45.0] [75-100]
	BASE EXCESS O2 SAT FIO2	The state of the s	2.0 95.9 40%	26.1H 2.7H 96.0	2.1	MMOL/L MMOL/L	
	PT TEMP CORR PH CORR PCO2 CORR PO2		38.0 H 7.47 35.8 79 SIMV			mmHG mmHG	(37.0 37.0)
	MODE ABG VT ABG VENT RATE SPONTANEOUS F SPONTANEOUS V		01 6 570 12			ML BPM BPM	
	CPR ARTERIAL LINE		NO YES				

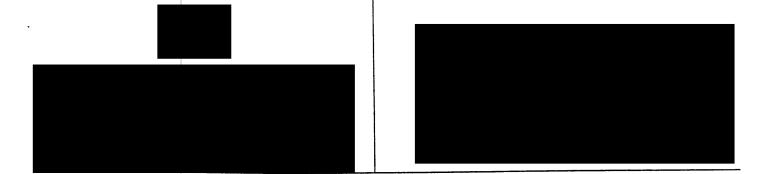
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Legend: L = Low, H = High

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LABORATORY REPORT



BEOOD GASES:

PROCEDURE	DATE TIME DAY	01/07/99 1400 <u>THU</u>	01/07/99 0800 <u>THU</u>	01/07/99 0200 THU	UNITS	REFERENCE RANGE
PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2 PT TEMP CORR PH CORR PCO2 CORR PO2 MODE ABG VT ABG VENT RATE PEEP ABG PRESSURE SUPP CPR ARTERIAL LINE	POR	7.49H 37.7 74L 28.2H 4.5H 95.9	7.50H 35.0 88 26.6H 3.4H 97.4 404 38.2H 7.48 36.9 95 SIMV 01 10 5 10 NO YES	4.3 H 97.4	MMHG MMHG MMOL/L MMOL/L MMOL/L % mmHG mmHG ML BPM CMH2O	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0] [37.0-37.0]

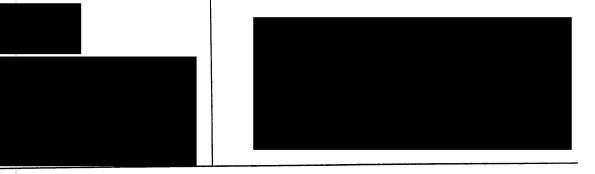
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LABORATORY REPORT

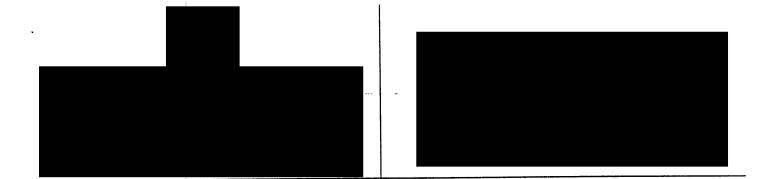


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PROCEDURE	DATE TIME DAY	01/06/99 2150 WED	01/06/99 1745 WED	01/06/99 0200 WED	UNITS	REFERENCE RANGE
PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT PT TEMP CORR PH CORR PCO2 CORR PO2	A Commence of the Commence of	7.50H 33.6L 92 25.4 2.5H 97.7	7.46H 37.3 80 26.2H 2.5H 96.4	7.49H 32.1L . 61L . 23.7 0.7 93.4L 38.5H 7.46 34.3 68	MMHG MMHG MMOL/L MMOL/L % mmHG mmHG	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0] [37.0-37.0]
PROCEDURE	DATE TIME DAY	01/05/99 1500 TUE	01/05/99 1000 TUE	01/05/99 0215 	UNITS	REFERENCE RANGE
PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2 PT TEMP CORR PH CORR PCO2 CORR PO2 MODE ABG VT ABG VENT RATE PEEP ABG PRESSURE SUP CPR ARTERIAL LIN		7.50H 35.5 125H 27.0H 3.9H 98.7H	7.47H 38.3 79 27.4H 3.6H 96.4 40% 38.3H 7.45 40.5 86 SIMV 1000 10 5 10 NO YES	7.47H 36.9 70L 26.0 2.4H 95.0	MMHG MMHG MMOL/L MMOL/L % mmHG mmHG ML BPM CMH2O	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0] [37.0-37.0]
Legend: L = Low, H =	High		CONTINUI	ED ON NEXT PAG	re PAG	GE: 31

LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS

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	PROCEDURE	DATE TIME DAY	01/04/99 1920 MON	01/04/99 1825 MON	01/04/99 1135 MON	UNITS	REFERENCE RANGE
)	PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2	Š. a. seriož	7.43 40.5 123H 26.2H 1.8 98.5H	7.53H 30.1L 73L 24.6 2.6H 96.3	7.49H 35.7 88 26.7H 3.5H 97.4 NA	MMHG MMHG MMOL/L MMOL/L	[7.35-7.45] [35.0-45.0] [75-100] [22.0-26.0] [-2.4-2.3] [95.0-98.0]
	PROCEDURE	DATE TIME DAY	01/04/99 0940 MON			UNITS	REFERENCE RANGE
•	PH ARTERIAL PCO2 PO2 ARTERIAL HC03 BASE EXCESS O2 SAT FIO2 PT TEMP CORR PH CORR PCO2 CORR PCO2 MODE ABG VT ABG VENT RATE PEEP ABG ARTERIAL LINE	3 .	7.46H 39.9 98 27.8H 3.8H 97.7 40% 36.9L 7.46 39.7 97 SIMV 1000 8 5	,		MMHG MMHG MMOL/L MMOL/L % mmHG mmHG ML BPM CMH2O	[7.35-7.45] $[35.0-45.0]$ $[75-100]$ $[22.0-26.9]$ $[-2.4-2.3]$ $[95.0-98.0]$ $[37.0-37.0]$

Legend:

L = Low, H = High

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LABORATORY REPORT

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PROCEDURE

UNITS REFERENCE RANGE

CSF ANALYSIS

COL	AITAL I DID				
CSF	SOURCE	CSF	VENTRIC		
CSF	TUBE #	TUBE# NA	TUBE# NA		()
CSF	COLOR	BROWN*	BROWN*	•	[NO COLOR]
CSF	APPEARANCE	CLOUDY*		The same of the sa	
CSF	XANTHOCHROM	3+*	3+*		
CSF	WBC COUNT	281H	9	_ MM3	[0-5]
CSF	RBC	92400H	231 61 H	MM3	[0-0]
CSF	NEUT %	51H	0L	%	[2-4]
CSF	LYMPHS%	36L	OL	€	[40-80]
CSF	MONO/MACRO%	13L	OL	€	[20-40]
CSF		73 H	76 H	MG/DL	[40-70]
CSF		1725 H	1331H	MG/DL	[12-60]

CHEMISTRY

DATE TIME DAY PROCEDURE	01/26/99 (0450 TUE	01/25/99 0430 MON	01/24/99 0504 SUN	UNITS	REFERENCE RANGE
ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	135L 4.1 95L 27 13	135L 3.9 94L 28 13	136L 3.9 95L 28 13	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]
INORGANIC/ORGANIC GLUCOSE CREATININE, SER BUN SERUM	121 H 0.9 13	121 H 0.9 14	126 H 0.9 15	MG/DL MG/DL MG/DL	[65-105] [0.8-1.5] [9-20]
Legend: L = Low, H = High,	* = Abnormal	CONTINU	ED ON NEXT PAG	PAC	000083 SE: 33

LABORATORY REPORT

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	DATE TIME DAY PROCEDURE	01/26/99 0450 TUE	01/25/99 0430 MON	01/24/99 0504 SUN	UNITS	REFERENCE RANGE
)	INORGANIC/ORGANIC BILIRUBIN TOTAL	0.5	0.4	0.4	MG/DL	[0.2-1.3]
	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE	155H 47 110 276H 80 357H	177H 44 118 290H 87 358H	214H 51 114 300H 100 442H	U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [15-73] [30-120] [23-300]
	DATE TIME DAY PROCEDURE	01/23/99 0444 SAT	01/22/99 1100 FRI	01/22/99 0550 FRI	UNITS	REFERENCE RANGE
)	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	136L 3.8 94L 29 13	277 L	133L 4.0 94L 28 11	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[3.6-5.0] [98-107] [22-30]
	INORGANIC/ORGANIC GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL MAGNESIUM	112H 0.9 14	,	120H 0.9 12 9.1 4.0 0.5 1.8	MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [1.3-1.9]
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L = Low, H = High

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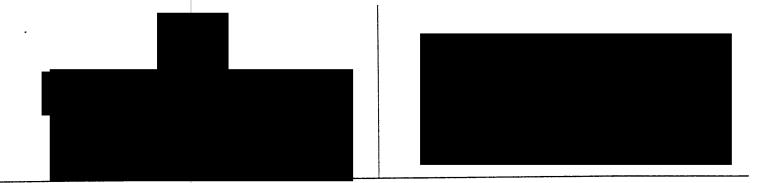
PAGE: 34

LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS

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				GHEMSHY.		-
	DATE TIME DAY PROCEDURE	01/23/99 0444 SAT	01/22/99 1100 FRI	01/22/99 0550 FRI	UNITS	REFERENCE RANGE
)	ENZYMES ALT AST ALK PHOS	240H 66H 111		259 H 90 H 99	U/L U/L	[21-72] [17-59] [38-126]
	GGT AMYLASE LIPASE	303H 117 420H				[15-73] [30-120] [23-300]
	DATE TIME DAY	01/21/99 0425 THU	01/20/99 0430 WED	01/19/99 1425 	INITEC	REFERENCE RANGE
	PROCEDURE				UNITS	REFERENCE RANGE
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	135L 4.3 95L 27 13	138 4.3 95 L 28 15	139 4.4 96 L 28 15	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]
)	INORGANIC/ORGANI		4.40**	4327	MG/DL	[65-105]
	GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL MAGNESIUM	134H 0.9 14 9.1 4.2 0.4 1.7	148H 0.9 22H 9.3 4.1 0.5 1.8	135H 0.9 9.4 4.6H	MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [1.3-1.9]
	ENZYMES ALT AST ALK PHOS GGT AMYLASE	218H 85H 98 301H 114	107		U/L U/L U/L U/L	[21-72] [17-59] [38-126] [15-73] [30-120]
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	L = Low, H = High		CONTINU	ED ON NEXT PAGE	PAC	SE: 35

LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



					CHEMISTRY			
		DATE FIME DAY	01/21/99 0425 THU	01/20/99 0430 WED	01/19/99 1425 TUE	UNITS	REFERENCE RANGE	
.	ENZYMES LIPASE		464 H	573 H		U/L	[23-300]	
		DATE FIME DAY	01/18/99 1412 MON	01/18/99 0435 MON	01/17/99 . 1430 SUN	_ UNITS	REFERENCE RANGE	
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	•	137 4.1 96 L 28 13	137 3.9 96 L 28 13	136L 4.3 96L 27 13	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]	
9	INORGANIC/ORG GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL		152H 0.9 9.1 4.0	142H 0.9 16 9.1 3.5 0.6 1.8	118H 0.8 9.2 3.8	MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] = [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [1.3-1.9]	
	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE			105H 62H 103 296H 149H 511H		U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]	

Legend:

L = Low, H = High

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LABORATORY REPORT

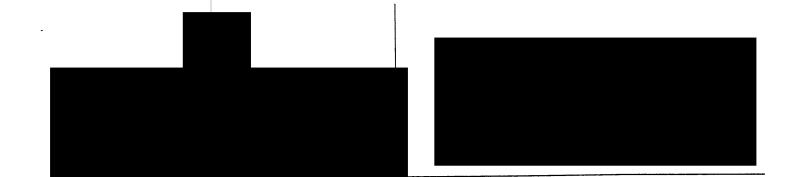
	PROCEDURE	DATE TIME DAY	01/17/99 0435 SUN	01/16/99 0220 SAT	01/15/99 1123 FRI	UNITS	REFERENCE RANGE
O	ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	s	136L 4.1 97L 26 13	138 4.2 97 L 30 11	138 4.5 • 97 L • 28 13	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[3.6-5.0] [98-107] [22-30]
	INORGANIC/OF GLUCOSE CREATININE, SE BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOT TOTAL PROTEIN ALBUMIN MAGNESIUM	R AL	139H 0.8 17 8.9 3.1 0.5	108H 0.9 8.8 3.7 0.8 7.0 3.5 1.8	120H 0.9 8.9 4.4 0.7 7.2 3.6 1.8	MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
9	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE		99H 47 111 303H 234H 995H	99H 39 93 256H 129H 419H	126H 52 93 272H 114 354H	U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]

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Legend: L = Low, H = High

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LABORATORY REPORT



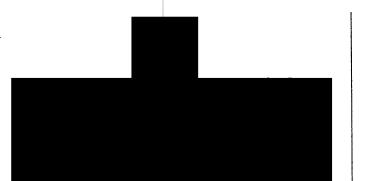
	PROCEDURE	DATE TIME DAY	01/15/99 0200 FRI	01/14/99 0240 THU	01/13/99 0200 WED	UNITS	REFERENCE RANGE
0	ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	S	137 4.5 96 L 30 11	138 4.3 98 28 12	138 4.4 . 98 . 26 14	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[3.6-5.0]
	INORGANIC/OF GLUCOSE CREATININE, SE BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOT TOTAL PROTEIN ALBUMIN MAGNESIUM	R AL	112H 0.9 19 8.9 4.1 0.5 7.0 3.6 1.8	133H 0.9 19 9.1 4.1 0.5 6.8 3.7 1.8	111H 0.9 17 9.2 4.1 1.2 7.9 4.3 1.7	MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
9	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE		137H 60H 96 288H 175H 735H	102H 44 95 286H 160H 694H	67 89 H 161 H 431 H 132 H 592 H	U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]

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Legend: L = Low, H = High

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LABORATORY REPORT





	DAT TIM DA PROCEDURE	Ε	01/12/99 0230 TUE	01/11/99 1405 MON	01/11/99 0830 MON	UNITS	REFERENCE RANGE
•	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY		137 4.7 99 25 13	138 4.8 99 26 13	138	MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORGAIGLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL TOTAL PROTEIN ALBUMIN MAGNESIUM	NIC	119H 0.9 15 9.3 4.2 0.7 7.3 4.0	97 0.8 14 9.0 4.3		MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
)	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE		132H 79H 112 484H 115 490H	,		U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]

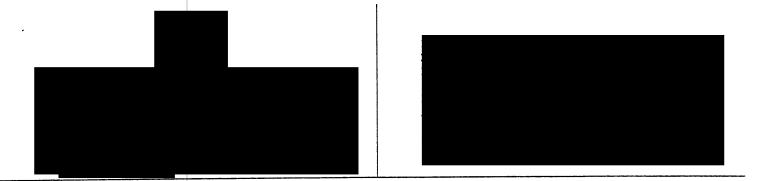
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LABORATORY REPORT



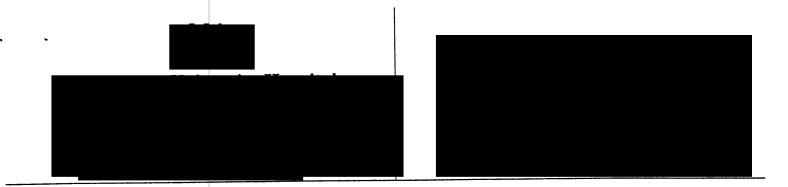
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	DATE TIME DAY PROCEDURE	01/11/99 0140 MON	01/11/99 0135 MON ^	01/10/99 1435 SUN	UNITS	REFERENCE RANGE
3	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP		138 4.3 98 26 14	140 4.5 . 102 . 24 14	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[3.6-5.0]
	INORGANIC/ORGANIC GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL TOTAL PROTEIN ALBUMIN MAGNESIUM	0.9 7.3 4.1	116H 0.9 12 9.3 3.9	118H 0.9 11 9.6 3.9	MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
الت	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE	122H 92H 115 420H 129H 472H			U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]

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LABORATORY REPORT



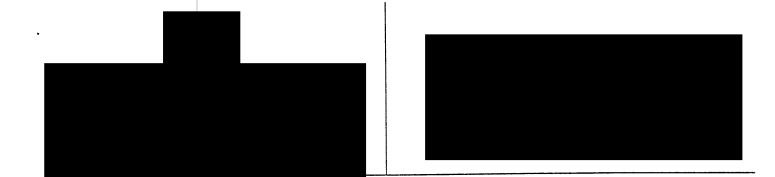
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	PROCEDURE	DATE TIME DAY	01/10/99 0230 SUN	01/09/99 2215 SAT ^	01/09/99 1430 SAT	UNITS	REFERENCE RANGE
•	ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	ES	139 3.9 104 25 10 286	138 286	138 3.5L 102 26 10 284	MMOL/L MMOL/L	• -
	INORGANIC/ORGLUCOSE CREATININE, SE BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOT TOTAL PROTEIN ALBUMIN MAGNESIUM	er Tal	102 0.9 11 8.5 3.6 0.7 6.1 L 3.2 L 1.9		99 0.9 10 8.4 2.9	MG/DL MG/DL MG/DL MG/DL MG/DL	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
0	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE		67 53 75 224 H 110 421 H	/		n/r .n/r .n/r n/r n/r	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]

Legend: L = Low, H = High

CONTINUED ON NEXT PAGE PAGE: 41

LABORATORY REPORT



	PROCEDURE	DATE TIME DAY	01/09/99 0815 SAT	01/09/99 0230 SAT ^	01/09/99 0200 SAT	UNITS	REFERENCE RANGE
	ELECTROLYTI SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	ES	138 283	139 3.6 105 24 10 287		MMOL/L	[3.6-5.0] [98-107] [22-30] [8-16]
	INORGANIC/O GLUCOSE CREATININE, SE BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOT TOTAL PROTEIN ALBUMIN MAGNESIUM	ER TAL		122H 0.9 12 8.0L 3.5 5.9L 1.6	0.7 3.2 L	MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
①	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE			,	50 38 63 191 H 70 286	U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300]

000092

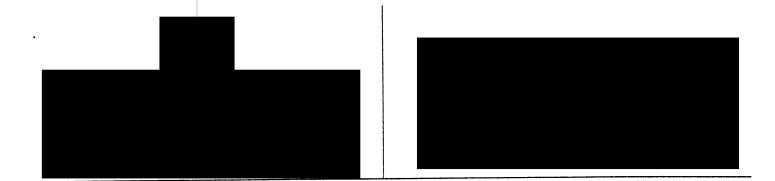
Legend: L = Low, H = High

CONTINUED ON NEXT PAGE PAGE: 42

LABORATORY REPORT

		ļ				
	DATE TIME DAY PROCEDURE	01/08/99 2030 FRI	01/08/99 1330 FRI	01/08/99 0840 FRI	UNITS	REFERENCE RANGE
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	141 286	143 3.7 109 H 27 7 L 295	146 H	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] [3.6-5.0] [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORGANIC GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS MAGNESIUM		119H 0.9 15 8.1L 3.2 1.7		MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [1.3-1.9]
9	DATE TIME DAY PROCEDURE	01/08/99 0330 FRI	01/07/99 1940 <u>THU</u>	01/07/99 1800 THU	UNITS	REFERENCE RANGE
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	144 4.0 110 H 25 9 299	144 3.9 298	3.7	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] [3.6-5.0] [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORGANIC GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS	119H 1.0 14 8.7 2.8			MG/DL MG/DL MG/DL MG/DL MG/DL	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4]
	Legend:					000093
	L = Low, H = High		CONTINU	ed on next f	PAGE PAG	E: 43

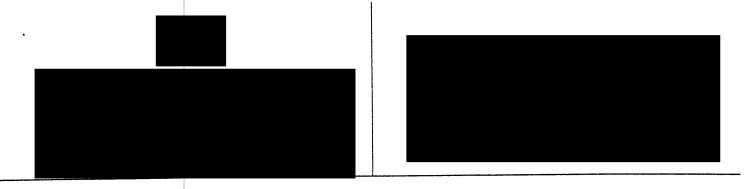
LABORATORY REPORT



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INORGANIC/ORGANIC BILIRUBIN TOTAL 0.9	Ξ
ALT AST AST ALK PHOS GGT AMYLASE LIPASE DATE DATE DATE DAY DAY DAY PROCEDURE 41 30 U/L [17-59] U/L [38-126] U/L [8-78] U/L [30-120] U/L [21-72] U/L [38-126] U/L [30-120] U/L [23-300] U/L [21-72] U/L [38-126] U/L [30-120] U/L [23-300] U/L [21-72] U/L [38-126] U/L [30-120] U/L [23-300] U/L [23-300]	
TIME 1400 0800 0300 DAY THU THU PROCEDURE UNITS REFERENCE RANGE	
FLECTROLYTES	Ξ
SODIUM	
INORGANIC/ORGANIC GLUCOSE	
Legend: L = Low, H = High CONTINUED ON NEXT PAGE PAGE: 44	

LABORATORY REPORT



DATE TIME DAY 01/07/99 1400 THU 01/07/99 0800 THU ^ 01/07/99 0300

PROCEDURE

UNITS REFERENCE RANGE

CARDIAC MARKER

TROPONIN I

0.11

NG/ML

[0.00-0.60]

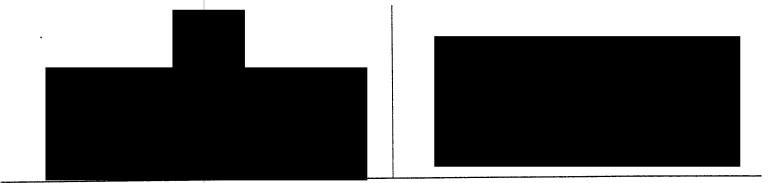
Healthy individuals have undetectable
Troponin. Typical AMI patients commonly
have values greater than 10 NG/ML. Lesser
ischemic insults extend to the lower level
of detectability (0.4 NG/ML) in a continuous
spectrum. Follow serially, comparable to
CKMB. Call for additional information.
LDH isoenzyme testing has been discontinued
as part of the cardiac profile. The
troponin I assay has been substituted. It
is consistently more sensitive and more
specific, available immediately and cost
effective. If you have further questions
or would like additional data, please call
Dr.

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LABORATORY REPORT



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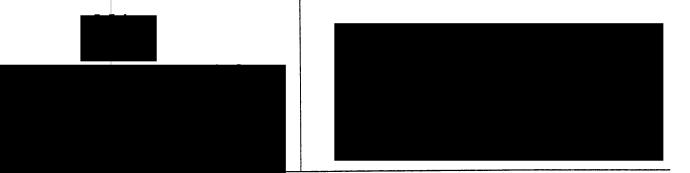
	DATE TIME DAY PROCEDURE	01/07/99 0200 THU	01/06/99 2150 WED ^	01/06/99 1745 WED	UNITS	REFERENCE RANGE
•	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	146H 3.9 111H 27 8 303H	144 4.2 111H 26 7L 303H	144 3.2L 110H 28 6L	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] [3.6-5.0] [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORGANIC GLUCOSE CREATININE, SER CALCIUM PHOSPHORUS BILIRUBIN TOTAL URIC ACID TOTAL PROTEIN ALBUMIN MAGNESIUM	143H 1.0 8.1L 2.5 1.2 3.0L 5.1L 2.7L	128H 1.1 8.0L 2.3L 3.2L	105 1.0 8.2L 2.6 2.5H 3.1L 4.5L 2.5L	MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [8.4-10.2] [2.4-4.4] [0.2-1.3] [3.5-8.5] [6.3-8.2] [3.5-5.0] [1.3-1.9]
9	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE CK-MB CK-MB INDEX	41 28 40 34 <30* 75 2.5 NOCALC*	,	36 26 31 L 30 2.5 NOCALC*	U/L U/L U/L U/L U/L U/L NG/ML	[21-72] [17-59] [38-126] [8-78] [30-120] [23-300] [0.0-3.0]
	CARDIAC MARKER TROPONIN I			0.23	NG/ML	[0.00-0.60]
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	Legend:	= Abnorma	1			

LABORATORY REPORT

L = Low, H = High, * = Abnormal

DISCHARGE - FINAL MEDICAL RECORDS

CONTINUED ON NEXT PAGE PAGE: 46



			CHEMISTR	Y	
		-			
DATE	01/06/99	01/06/99 0200	01/05/99 1900		

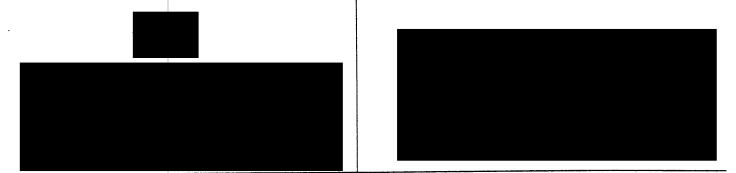
		DATE FIME DAY	01/06/99 0410 WED	01/06/99 0200 WED_*	01/05/99 1900 TUE			
	PROCEDURE			,		UNITS	REFERENCE RANGE	
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 OSMOLALITY	;	144	3.2L 109H 25 295	145 3.6 294	MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [280-300]	
	INORGANIC/ORG GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS MAGNESIUM	GANIC		139H 1.0 12 8.3L 2.9 1.9		MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [1.3-1.9]	
-		DATE FIME DAY	01/05/99 1425 TUE	01/05/99 1000 TUE	01/05/99 0215 TUE	UNITS	REFERENCE <u>~</u> RANGE	
3	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	3	294	144 3.2 L	140 3.8 103 27 10 292	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[3.6-5.0] [98-107]	
	INORGANIC/ORG GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS MAGNESIUM			115H 1.1 8.0L 3.4 2.0H	121H 1.0 13 9.2 2.7 1.8	MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [1.3-1.9]	
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LABORATORY REPORT

L = Low, H = High

DISCHARGE - FINAL MEDICAL RECORDS

CONTINUED ON NEXT PAGE PAGE: 47



CF	HE	MI:	ST	RY

	PROCEDURE	DATE TIME DAY	01/04/99 2320 MON	01/04/99 1920 MON ^	01/04/99 1715 MON	UNITS	REFERENCE RANGE
9	ELECTROLYTE SODIUM POTASSIUM	:5	143		142 3.6	MMOL/L MMOL/L	-
	OSMOLALITY		295		. 292	MOSM/K	[280-300]
	MISCELLANEC HOMOCYSTEINE, NORMAL RANGE	P	(10/29/98	10 Current) SPECIMENS		^ MMOL/L	[0-13]
		DATE TIME DAY	01/04/99 0820 MON	01/04/99 0240 MON	01/03/99 2015 SUN		
	PROCEDURE	DAI	<u> </u>	11011		UNITS	REFERENCE RANGE
0	ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	≣S	142 3.2L 106 27 9 294	140 3.5L 99 30 11 294	291	MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] [3.6-5.0] = [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORGLUCOSE CREATININE, SE BUN SERUM CALCIUM PHOSPHORUS MAGNESIUM		107H 1.0 15 7.5L 4.4 2.1H	112H 1.0 17 9.2 3.0 1.7		MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [1.3-1.9]

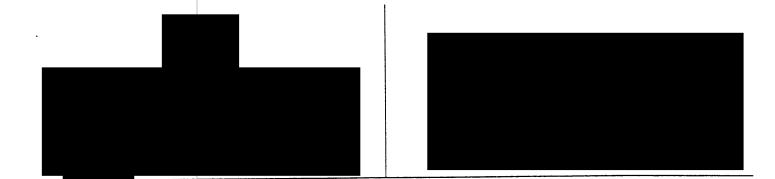
Legend: L = Low, H = High

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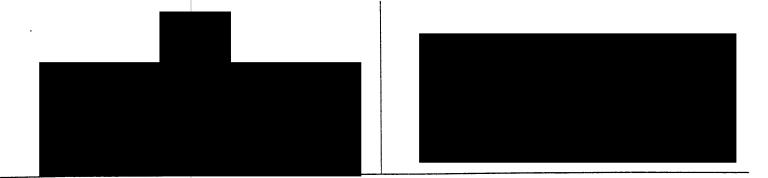
LABORATORY REPORT



			Ŀ		CHEMISTR		
		DATE TIME DAY	01/03/99 1640 SUN	01/03/99 1215 SUN ^	01/03/99 0735 SUN		
	PROCEDURE			,		UNITS	REFERENCE RANGE
	ELECTROLYTE OSMOLALITY	S	294	289	293	MOSM/K	[280-300]
	INORGANIC/OF CREATININE, SE BUN SERUM			ار مارونی	1.1 15	MG/DL _ MG/DL	[0.8-1.5] [9-20]
	PROCEDURE	DATE TIME DAY	01/03/99 0345 SUN	01/03/99 0040 SUN	01/03/99 0011 SUN	UNITS	REFERENCE RANGE
<u> </u>	ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	ES .	292	139 4.0 100 29 10 291	293	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]

CONTINUED ON NEXT PAGE PAGE: 49

LABORATORY REPORT



					CHEMISTRY		
		DATE TIME DAY	01/02/99 1945 SAT	01/02/99 1530 	01/02/99 1205 SAT	UNITS	REFERENCE RANGE
0	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	•	293	292	141 4.0 - 101 - 30 10 - 291	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] [3.6-5.0] [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORG	GANIC			1.6	MEQ/L	[1.3-1.9]
		DATE TIME DAY	01/02/99 0845 SAT	01/02/99 0355 SAT	01/01/99 2201 FRI	UNITS	REFERENCE RANGE
O	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP OSMOLALITY	6	292	139 3.9 101 29 9	140 3.8 102 30 8 288	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L MOSM/K	[137-145] = [3.6-5.0] [98-107] [22-30] [8-16] [280-300]
	INORGANIC/ORG GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS MAGNESIUM			115H 1.2 9 9.1 5.6H 1.5	1.1 9 8.9 4.3 1.5	MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [1.3-1.9]
						00	0100
	Legend: H = High			CONTINU	ed on next page	PAC	GE: 50

LABORATORY REPORT

DISCHARGE - FINAL MEDICAL RECORDS

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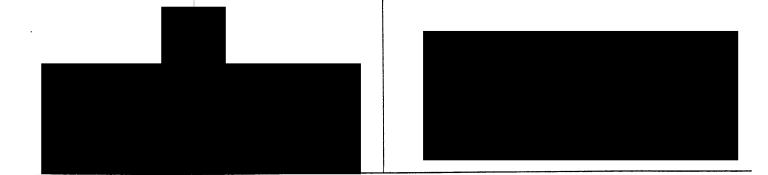
PROCEDURE	DATE TIME DAY	01/01/99 1050 FRI	12/31/98 1140 THU	12/31/98 0254 THU	UNITS	REFERENCE RANGE
ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	S	141 3.7 103 29 9		.÷	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]
INORGANIC/OF GLUCOSE CREATININE, SE BUN SERUM CALCIUM PHOSPHORUS MAGNESIUM		114H 1.1 7L 8.8 4.2 1.6			MG/DL MG/DL MG/DL MG/DL MG/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [1.3-1.9]
CARDIAC MAR	KER		0.05		NG/ML	[0.00-0.60]
LIPOPROTEINS CHOLESTEROL TRIGLYCERIDES HDL CHOLESTER				135 83 61	MG/DL MG/DL MG/DL	[120-199] [50-199] [35-80]

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Legend: L = Low, H = High

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LABORATORY REPORT



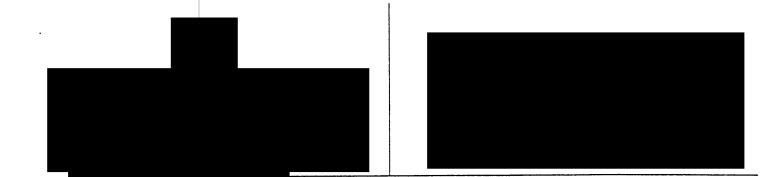
	DATE TIME DAY PROCEDURE	12/31/98 0200 THU	12/30/98 1825 WED	12/30/98 1800 WED	UNITS	REFERENCE RANGE
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP		141 3.6 105 25 11		MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]
	INORGANIC/ORGANIC GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL TOTAL PROTEIN ALBUMIN MAGNESIUM	1.7 H 7.1 4.2	119H 1.0 13 8.6 2.1L		MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL G/DL MEQ/L	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]
9	ENZYMES ALT AST ALK PHOS GGT	42 31 51 23			U/L U/L U/L U/L	[21-72] [17-59] [38-126] [8-78]
	CARDIAC MARKER TROPONIN I 12/31/98 0200	OOTNOTE* f LESS THAN 0 BELOW LINEAR	.03 NG/ML RITY OF TH	0.08 E INSTRUMENT.	NG/ML	[0.00-0.60]

000102

L = Low, H = High, * = Abnormal, f = Footnote

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LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



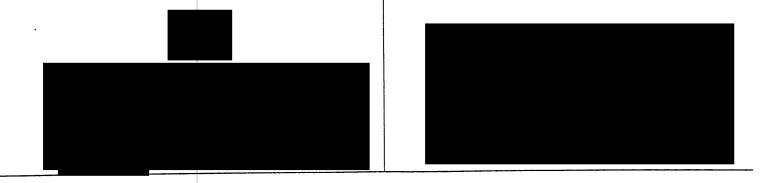
		THEI	RAPEUTIC D	RUGS	
DATE TIME DAY PROCEDURE	01/25/99 0430 MON	01/22/99 0550 FRI	01/21/99 0425 THU	UNITS	REFERENCE RANGE
ANTICONVULSANTS PHENYTOIN (05/19/97 THERAPEUTIC TOXIC: GREA			9.1L	UG/ML	
DATE TIME DAY PROCEDURE	01/20/99 0430 WED	01/19/99 1425 TUE	.01/18/99 1412 MON	~ UNITS	REFERENCE RANGE
ANTICONVULSANTS PHENYTOIN	12.8	13.4	13.2	UG/ML	
DATE TIME DAY PROCEDURE	01/18/99 0435 MON	01/17/99 1430 SUN	01/17/99 0435 SUN	UNITS	REFERENCE RANGE
ANTICONVULSANTS PHENYTOIN	12.9	12.2	10.3	UG/ML	-

Legend: L = Low

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LABORATORY REPORT



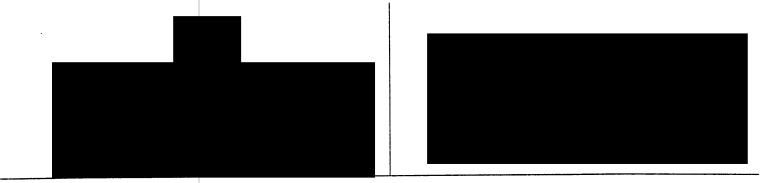
	;	THE	RAPEUTIC I	DRUGS	
DATE TIME DAY PROCEDURE	01/16/99 0220 SAT	01/15/99 0200 FRI	01/14/99 0240 THU	UNITS RE	FERENCE RANGE
ANTICONVULSANTS PHENYTOIN	9.7L	8.2L	5.4L	UG/ML	
DATE TIME DAY PROCEDURE	01/13/99 0200 WED	01/12/99 0230 TUE	01/11/99 . 1405 MON	UNITS RE	FERENCE RANGE
ANTICONVULSANTS PHENYTOIN	29.5 Cf	11.9	13.3	UG/ML	
01/13/99 0200 DATE	CRITICAL RI RESULTS REI	ESULTS CALLI PEATED AND V 01/10/99	ED TO: /ERIFIED 01/10/99	IN ICU AT 01/13/	99 04:02 BY
TIME DAY PROCEDURE	0140 MON	1435 SUN	0230 SUN	UNITS RE	FERENCE RANGE
ANTICONVULSANTS PHENYTOIN	17.4	14.2	13.0	UG/ML	<u>*</u>

L = Low, C = Critical, f = Footnote

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LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



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TIME DAY	1430 SAT	0200 SAT	1330 FRI		
PROCEDURE)		UNITS	REFERENCE RANGE
ANTICONVULSANTS PHENYTOIN	14.0	17.4	19.8	UG/ML	
DATE TIME DAY	01/08/99 0330 FRI	01/07/99 1400 THU	01/07/99 . 0910 THU		
PROCEDURE		£		_ UNITS	REFERENCE RANGE
ANTIBIOTICS VANCO PEAK			12.0L	UG/ML	

(03/24/94 -- Current)

THERAPEUTIC RANGE: 30-40 UG/ML TOXIC: GREATER THAN 80 UG/ML

ANTICONVULSANTS

PHENYTOIN

19.6

21.9H

DATE 01/09/99 01/09/99 01/08/99

UG/ML

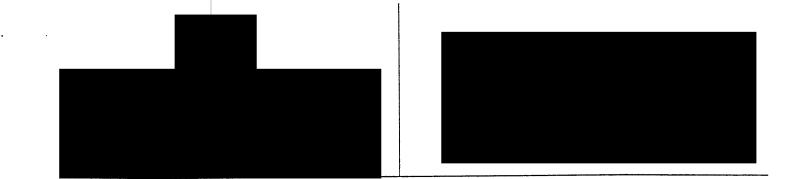
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Legend:

L = Low, H = High

CONTINUED ON NEXT PAGE PAGE: 55

LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



THERAPEUTIC DRUGS

	DATE TIME	01/07/99 0600	01/07/99 0530 THU	01/07/99 0200 THU
	DAY	THU		
PROCEDURE			•	

UNITS REFERENCE RANGE

ANTIBIOTICS

VANCO TROUGH 3.1L UG/ML

(03/24/94 -- Current) THERAPEUTIC RANGE: 5-10 UG/ML TOXIC: GREATER THAN 80 UG/ML

4. **ANTICONVULSANTS** UG/ML PHENYTOIN 19.4 [1.0-2.0]UG/ML 2.4H FREE PHENYTOIN 01/05/99 01/05/99 DATE 01/06/99 1000 TIME 0200 1900 TUE TUE DAY WED UNITS REFERENCE RANGE PROCEDURE

ANTICONVULSANTS
PHENYTOIN 18.3 20.4H 10.6 UG/ML

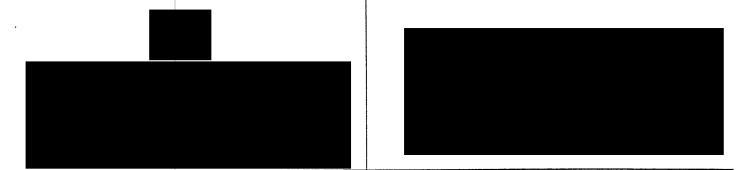
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Legend: L = Low, H = High

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LABORATORY REPORT



			, , ,	A CONTRACTOR	RAPEUTIC DI	RUGS	
	PROCEDURE	DATE TIME DAY	01/05/99 0215 TUE	01/04/99 2338 MON	01/04/99 1920 MON	UNITS	REFERENCE RANGE
•	ANTIBIOTICS GENTAMICIN			0.3		UG/ML	
	ANTICONVULS PHENYTOIN		12.9	شرر ر ب ني	11.6	UG/ML	
	PROCEDURE	DATE TIME DAY	01/04/99 0820 MON	2 74		UNITS	REFERENCE RANGE
	ANTICONVULS PHENYTOIN	SANTS	12.4			UG/ML	
~				(Section 1981) Dr	RUGS OF AB	USE A	i di
9	PROCEDURE	DATE TIME DAY	12/30/98 1825 WED			UNITS	REFERENCE RANGE
	AMPHETAMINES 12/30/9 BARBITURATES BENZODIAZEPIN COCAINE OPIATES PHENCYCLIDINE TETRAHYDROCAN	18 1825 IES 1 I	NEGATIVE E TEST PERFORM NEGATIVE NEGATIVE NEGATIVE NEGATIVE NEGATIVE	RMED AT			[NEGATIVE] [NEGATIVE] [NEGATIVE] [NEGATIVE] [NEGATIVE] [NEGATIVE]

Legend:

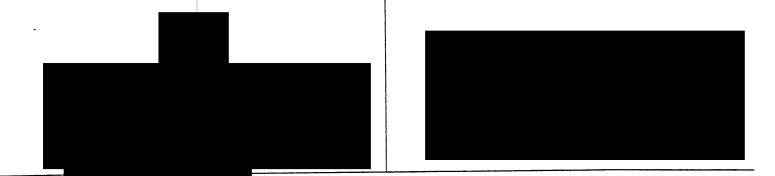
f = Footnote

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LABORATORY REPORT



IMMUNOLOGY

01/04/99 01/06/99 DATE 1920 1745 TIME MON WED DAY

PROCEDURE

137.0f

REFERENCE RANGE

TOTAL IGA

01/06/99 1745 IGA-BLOOD

MG/DL [60.0-400.0] 137.0 MG/DL REFERENCE RANGE: 68-378

TEST PERFORMED AT.

CARDIOLIPIN IGG

4.8f 01/04/99 1920 COMMENT: NORMAL

GPL [.0-23.0]

UNITS

CARDIOLIPIN IGM

2.1f 01/04/99 1920 COMMENT: NORMAL

MPL [0.0-9.0]

CARDIOLIPIN IGA

DLIPIN IGA 5.8f 01/04/99 1920 COMMENT: NORMAL

[0.0-22.0] APL

INFECTIOUS DISEASE SEROLOGY

12/30/98 DATE 1825 TIME DAY

PROCEDURE

WED

UNITS

REFERENCE RANGE

NON REAC

[NON REAC]

(06/24/97 -- Current)

MHA-TP

RPR

NONREAC

[NONREAC]

000108

Legend: f = Footnote

CONTINUED ON NEXT PAGE

PAGE: 58

LABORATORY REPORT



DATE TIME DAY 01/04/99 1920 MON

PROCEDURE

REFERENCE RANGE UNITS

REFERENCE RANGE: HOMOZYGOUS NORMAL

MISC TEST

FOOTNOTE* f

01/04/99 1920

PROTHROMBIN G20210A MUTATION ANALYSIS

RESULTS: HOMOZYGOUS NORMAL (WT/WT)

INTERPRETATION:

MOLECULAR ANALYSIS FOR THE PROTHROMBIN G20210A MUTATION WAS NEGATIVE. FINAL DIAGNOSIS REQUIRES CORRELATION WITH CLINICAL HISTORY AND PRO-THROMBIN LEVELS.

TEST PERFORMED AT

ORDERED PROCEDURES THAT ARE PENDING

01/04/99 1946

FACTOR V LEIDEN MUTATION

RECVD



CANCELLED ORDERS

PT DISCHAR

GLUCOSE

01/16/99 1207

000109

Legend:

* = Abnormal, f = Footnote

CONTINUED ON NEXT PAGE

PAGE: 60

LABORATORY REPORT

Institution:

Reg. Physician:

Hospital #:

Ref. Spec ID:

Specimen: EDTA Whole Blood

Clin Dx:1:

Clin Dx:2:

Molecular Lab #:

Date Drawn:

Jan 4, 1999

Date Rec'd:

Jan 5, 1999

Date Final:

Jan 8,-1999

Date Prelim:

Date Ammended:

FINAL REPORT

Prothrombin G20210A Mutation Analysis*

RESULTS:

Reference Range:

Homozygous Normal

Homozygous normal (WT/WT)

INTERPRETATION:

Molecular analysis for the Prothrombin G20210A mutation was negative. Final diagnosis requires correlation with clinical history and prothrombin levels.

In addition to the factor V mutation, ~18% of those with recurrent, familial venous thrombosis have recently been shown to carry another very common mutation, a heterozygous G-->A substitution at nucleotide 20210 of the prothrombin gene. This G20210A mutation is also quite common in the

normal population (affecting ~2% of healthy controls), and among these carriers, there is a significant three-fold increased risk of venous thrombosis.

> This assay is for research purposes only and should not be used as the sole criteria for clinical decision making. These results must be interpreted along with the clinical history and other pertinent laboratory data for this patient.

ASR DISCLAIMER: Analyte specific Reagents (ASRs) such as nucleic acid sequences are used in many laboratory tests to provide optimal medical care and generally do not require FDA approval. This test was developed and its performance characteristics determined by the It has not been cleared or approved by the U.S. Food and Drug Administration.

000110

Consultants:

Institution:

Reg. Physician: Hospital #:

Ref. Spec ID:

Specimen: EDTA Whole Blood

Clin Dx:1:

Clin Dx:2:

Molecular Lab #:

Date Drawn:

Jan 4, 1999

Date Rec'd:

Jan 5, 1999 Jan 8, -1999

Date Final:

Date Prelim:

Date Ammended:

FINAL REPORT

Factor V Leiden Mutation Analysis*

RESULTS:

Homozygous normal (WT/WT)

Reference Range:

Homozygous Normal

INTERPRETATION:

Consultants:

Molecular analysis for the Factor V Leiden mutation was negative. Final diagnosis requires correlation with clinical history and activated Protein C Sensitivity ratio assay.

000111

This assay is for research purposes only and should not be used as the sole criteria for clinical decision making. These results must be interpreted along with the clinical history and other pertinent laboratory data for this patient.

PRINCIPLE OF ASSAY: A recent newly recognized defect in the coagulation pathway has been shown to be responsible for a hypercoagulable state and is thought to be the most common risk factor in venous thrombosis. The defect is at the site of the Factor V molecule normally cleaved by activated Protein C. Two assays are available for assessing the presence of this mutation. The Activated Protein C (APC) sensitivity assay is a screening assay which measures the functional resistance of Factor V to APC cleavage. A confirmatory assay is now available which analyzes directly for the genetic defect. The mutation, known as the Factor V Leiden Mutation, involves a base pair change at the DNA level which causes an amino acid change affecting the cleavage site of the protein. The defective factor V protein is resistant to inactivation by protein C. This is believed to result in the physiological complications noted in these patients.

The molecular assay uses the polymerase chain reaction to amplify genomic DNA surrounding the mutation. The amplified product is then cut with a restriction enzyme (Mnl I). When present, the mutation destroys an Mnl I site generating a longer fragment than the normal gene. This size difference is evaluated following polyacrylamide gel electrophoresis and ethidium bromide staining of the amplified DNA. The results obtained identify homozygote normal individuals, heterozygote carriers and homozygote carriers of the defect.

heterozygote carriers and homozygote carriers of the defect.

UTILITY OF ASSAY: Homozygotes for the mutation, that is, individuals carrying copies of the mutation on both chromosomes, have been shown to have low activated protein C sensitivity ratios. These individuals are clearly at increased risk for a significant thrombotic event during their lifetime. Individuals carrying a single copy of the genetic defect, or heterozygotes, may also be predisposed to a significant thrombotic event when coupled to additional risk factors. For example, pregnant women or women on oral contraceptives who carry this defect have been shown to have up to a 30-fold higher risk for development of deep vein thromboses.

ASSAY LIMITATIONS: The mutation is present in approximately 5% of individuals of Northern European descent. With a population incidence this high, it has been shown that some individuals with Protein C and Protein S defects are in fact compound heterozygotes that also carry the factor V Leiden mutation. The incidence of the mutation is <1% in African-American or Native North-American/Hispanic individuals.

ASR DISCLAIMER: Analyte specific Reagents (ASRs) such as nucleic acid sequences are used in many laboratory tests to provide optimal medical care and generally do not require FDA approval. This test was developed and its performance characteristics determined by the enerally do not require FDA approval. This test was developed and its performance characteristics determined by the enerally do not require FDA approval. This test was developed and its performance characteristics determined by the enerally do not require FDA approval.

Page 1 of 1

institution: Reg. Physician: Hospital #:

Ref. Spec ID: Specimen: EDTA Whole Blood

Clin Dx:1:

Clin Dx:2:

Molecular Lab #:

Date Drawn:

Jan 4, 1999 Jan 5, 1999

Date Rec'd: Date Final:

Jan 8, 1999

Date Prelim:

Date Ammended:

FINAL REPORT

Factor V Leiden Mutation Analysis*

RESULTS:

Homozygous normal (WT/WT)

Reference Range:

Homozygous Normal

INTERPRETATION:

Molecular analysis for the Factor V Leiden mutation was negative. Final diagnosis requires correlation with clinical history and activated Protein C Sensitivity ratio assay.

ساز ساريجي

000112

This assay is for research purposes only and should not be used as the sole criteria for clinical decision making. These results must be interpreted along with the clinical history and other portinent laboratory data for this patient.

PRINCIPLE OF ASSAY: A recent newly recognized defect in the congulation pathway has been shown to be responsible for a hypercoagulable state and is thought to be the most common risk factor in venous thrombosis. The defect is at the site of the Factor V molecule normally cleaved by activated Protein C. Two assays are available for assessing the presence of this miniation. The Activated Protein C (APC) sensitivity assay is a sectenting assay which measures the functional resistance of Pactor V to APC cleavage. A confirmatory assay is now available which analyzes directly for the genetic defect. The mutation, known as the Factor V Leiden Mutation, involves a base pair change at the DNA level which causes an amino acid change affecting the cleavage site of the protein. The defective factor V protein is resistant to inactivation by protein C. This is believed to result in the physiological complications noted in these putients.

The molecular assay uses the polymerate chain reaction to amplify genomic DNA surrounding the mutation. The amplified product is then cut with a restriction enzyme (Mnt I). When present, the mutation destroys an Mnl I site generating a longer fragment than the normal gone. This size difference is evaluated following polyacrylamide gel electrophorasis and ethicium bromide staining of the amplified DNA. The results obtained identify homozygote normal individuals, heterozygote carriers and homozygote carriers of the defect.

UTILITY OF ASSAY: Homozygotes for the mussion, that is, individuals carrying copies of the mussion on both chromosomes, have been shown to have low activated procein C sensitivity ratios. These individuals are clearly at increased risk for a significant thrombotic event thiring their lifetime. Individuals carrying a single copy of the genetic defect, or heterozygotes, may also be predisposed to a significant thrombotic event when coupled to additional risk factors. For example, pregnant women or women on oral contraceptives who carry this defect have been shown to have up to a 30-fold higher risk for development of deep vein

ASSAY LIMITATIONS: The mutation is present in approximately 5% of individuals of Northern European descent. With a population incidence this high, it has been shown that some individuals with Protein C and Protein S defects are in fact compound historoxygotes that also carry the factor V Leiden mutation. The incidence of the mutation is <1% in African-American or Native North-American/Hispanic individuals.

ASR DISCLAIMER: Analyte specific Reagons (ASRs) such as nucleic acid sequences are used in many laboratory tests to provide optimal medical care and generally do not require FDA approval. This test was developed and its performance characteristics determined by the Laboratory for the u.s. Food and Drug Administration.

Consultants:

institution:

Rog. Physician: Hospital #:

Ref. Spec ID;

Specimen: EDTA Whole Blood

Clin Dx:1: Clin Dx:2: Molecular Lab #:

Date Drawn: Date Rec'd:

Jan 4, 1999 Jan 5, 1999 Jan 8, 1999

Date Final:

Date Prelim:

Date Ammended:

FINAL REPORT

Prothrombin G20210A Mutation Analysis*

RESULTS:

Homozygous normal (WT/WT)

Reference Range:

Homozygous Normal

INTERPRETATION:

Molecular analysis for the Prothrombin G20210A mutation was negative. Final diagnosis requires correlation with clinical history and prothrombin levels.

In addition to the factor V mutation, -18% of those with recurrent, familial venous thrombosis have recently been shown to carry another very common mutation, a heterozygous G->A substitution at nucleotide 20210 of the prothrombin gene. This G20210A mutation is also quite common in the

normal population (affecting -2% of healthy controls), and among these carriers, there is a significant three-fold increased risk of venous thrombosis.

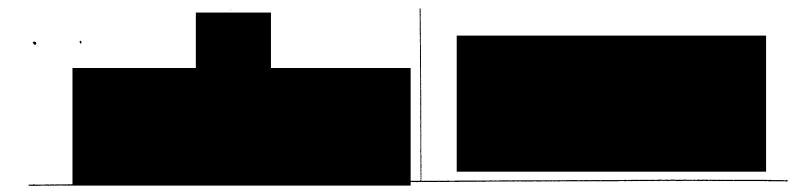
> This assay is for research purposes only and should not be used as the sole enteria for clinical decision making. These results must be interpressed along with the clinical history and other pertinent laboratory data for this patient.

ASR DISCLAIMER: Analyte specific Reagents (ASRs) such as nucleic acid sequences are used in many laboratory tests to provide optimal medical care and generally do not require PDA approval. This test was developed and its performance characteristics detarmined by the it has not been cleared or approved by the U.S. Food and Drug Administration.

000113

Consultants:

Date: 1/9/99



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CANCELLED ORDERS

RN REQUEST	
RN REQUEST	
NO SPEC	
CAN'T PREP	
RN REQUEST	
CAN'T PREP	
RN REQUEST	
RN REQUEST	

CALCIUM	01/01/99 1009
MAGNESIUM	01/01/99 1009
PHOSPHORUS	01/01/99 1009
INR GROUP	01/01/99 1009
PARTIAL THROMBOPLASTIN TIME	12/31/98 1827
UREA NITROGEN BLOOD	01/01/99 1009
TROPONIN-I	12/30/98 1928
LDL (DIRECT)	12/30/98 1817
TROPONIN-I	12/30/98 1928
HEMOGRAM + PLATELETS	12/30/98 1741
ARTERIAL BLOOD GASES	12/30/98 1741

BLOOD CULTURES

CATH TIP CULT SOURCE: CATH_TIP RT IJ TIP COLLECTED: 01/09/99 1600 RECEIVED: 01/09/99 1607 STARTED: 01/09/99 1641

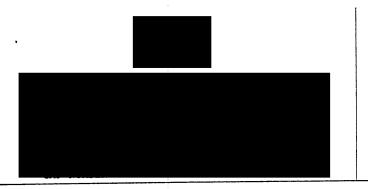
----FINAL REPORT-----01/12/99 0741

NO GROWTH

000114

CONTINUED ON NEXT PAGE PAGE: 81

LABORATORY REPORT





BLOOD CULTURES

BLOOD CULTURE

SOURCE: BLOOD

PERIPHERAL-RT ARM

COLLECTED: 01/05/99 1457

RECEIVED: 01/05/99 1504

STARTED: 01/05/99 1532

-----FINAL REPORT-----01/11/99 0916

NO GROWTH AT 5 DAYS

BLOOD CULTURE

SOURCE: BLOOD

ART LINE DRAW

COLLECTED: 01/05/99 1425

RECEIVED: 01/05/99 1456

STARTED: 01/05/99 1531

-----FINAL REPORT-----<u>-</u> σ1/11/99 0916

NO GROWTH AT 5 DAYS

URINE CULTURES

URINE CULTURE

SOURCE: CATHERIZED URINE, IN AND OUT

FOLEY URINE

COLLECTED: 01/05/99 1440

RECEIVED: 01/05/99 1457

STARTED: 01/05/99 1528

-----FINAL REPORT-----01/07/99 0947

NO GROWTH

STERILE BODY FLUIDS

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

CSF #5 VENTRIC

COLLECTED: 01/14/99 1805

RECEIVED: 01/14/99 1857

STARTED: 01/14/99 1900

---STAINS/PREPS REPORT---

GRAM STAIN FEW WBC'S SEEN

NO ORGANISMS SEEN

01/15/99 0848

----FINAL REPORT-----01/17/99 1252

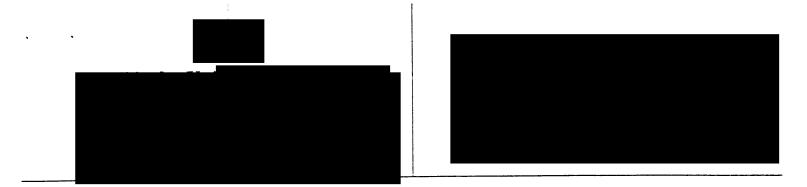
000115

NO GROWTH

CONTINUED ON NEXT PAGE

PAGE: 82

LABORATORY REPORT



STERILE BODY FLUIDS

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

CSF #6

COLLECTED: 01/14/99 1800

RECEIVED: 01/14/99 1854 STARTED: 01/14/99 1900

GRAM STAIN FEW WBC'S SEEN NO ORGANISMS SEEN

----STAINS/PREPS REPORT---01/15/99 0847

----FINAL REPORT-----01/17/99 1252

NO GROWTH

STERILE SITE SOURCE: CEREBROSPINAL FLUID

VENTRIC #1

COLLECTED: 01/13/99 1300

RECEIVED: 01/13/99 1312 STARTED: 01/13/99 1339

GRAM STAIN ABUNDANT RBC'S SEEN FEW WBC'S SEEN

NO ORGANISMS SEEN

----STAINS/PREPS REPORT---01/13/99 1452

-----FINAL REPORT-----01/16/99 1003

NO GROWTH

STERILE SITE SOURCE: CEREBROSPINAL FLUID

CSF

COLLECTED: 01/12/99 1130 RECEIVED: 01/12/99 1137

STARTED: 01/12/99 1157

GRAM STAIN ABUNDANT RBC'S SEEN FEW WBC'S SEEN NO ORGANISMS SEEN

NO GROWTH

----STAINS/PREPS REPORT---01/12/99 1514

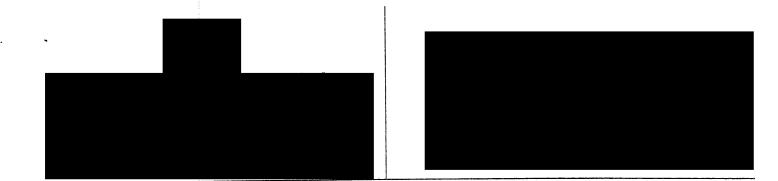
-----FINAL REPORT-----01/15/99 0921

000116

CONTINUED ON NEXT PAGE

PAGE: 83

LABORATORY REPORT



STERILE BODY FLUIDS

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

VENTRIC 6 CSF

---STAINS/PREPS REPORT---01/12/99 1514

GRAM STAIN ABUNDANT RBC'S SEEN FEW WBC'S SEEN NO ORGANISMS SEEN

NO GROWTH

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

CSF

GRAM STAIN ABUNDANT RBC'S SEEN FEW WBC'S SEEN

NO ORGANISMS SEEN

---STAINS/PREPS REPORT---01/09/99 1502

----FINAL REPORT-----01/16/99 0916

-----FINAL REPORT-----01/12/99 1153

NO GROWTH

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

CSF-VENTRIC

GRAM STAIN FEW WBC'S SEEN NO ORGANISMS SEEN

NO GROWTH

COLLECTED: 01/08/99 1430

COLLECTED: 01/12/99 1130

RECEIVED: 01/12/99 1148

COLLECTED: 01/09/99 1100

RECEIVED: 01/09/99 1244

STARTED: 01/09/99 1320

STARTED: 01/12/99 1159

RECEIVED: 01/08/99 1524

STARTED: 01/08/99 1603

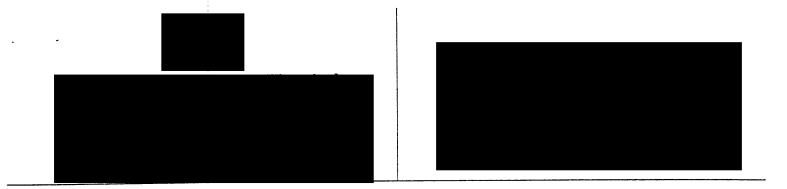
---STAINS/PREPS REPORT---01/08/99 1700

-----FINAL REPORT-----01/11/99 1153

000117

CONTINUED ON NEXT PAGE PAGE: 84

LABORATORY REPORT



STERILE BODY FLUIDS

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

CSF

COLLECTED: 01/07/99 1130

RECEIVED: 01/07/99 1146 STARTED: 01/07/99 1150

----STAINS/PREPS REPORT---01/07/99 1420

-----FINAL REPORT-----01/10/99 1219

FEW WBC'S SEEN NO ORGANISMS SEEN

NO GROWTH

GRAM STAIN

RESPIRATORY CULTURES

RESPIRATORY CUL SOURCE: SPUTUM

TRANS-TRACHEAL

COLLECTED: 01/05/99 1445 RECEIVED: 01/05/99 1456

STARTED: 01/05/99 1518

----STAINS/PREPS REPORT---01/05/99 1608

GRAM STAIN ABUNDANT WBC'S SEEN MODERATE GRAM POSITIVE RODS FEW GRAM POSITIVE COCCI FEW GRAM NEGATIVE RODS

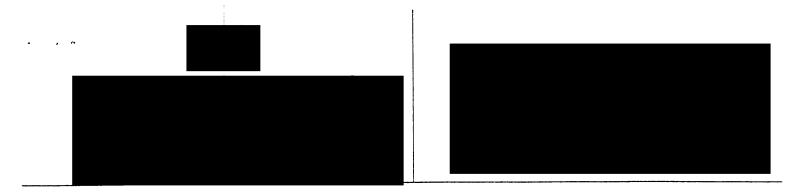
> ----FINAL REPORT-----01/08/99 1118

LIGHT GROWTH NORMAL ORAL FLORA ISOLATED

000118

CONTINUED ON NEXT PAGE PAGE: 85

LABORATORY REPORT



RESPIRATORY CULTURES

RESPIRATORY CUL SOURCE: SPUTUM

SPUTUM

COLLECTED: 01/04/99 1450 RECEIVED: 01/04/99 1458

STARTED: 01/04/99 1502

----STAINS/PREPS REPORT---01/04/99 1522

GRAM STAIN

MANY LEUKOCYTES

FEW GRAM POSITIVE COCCI IN CHAINS AND PAIRS

FEW GRAM NEGATIVE RODS FEW GRAM POSITIVE RODS

-----FINAL REPORT----01/09/99 1122

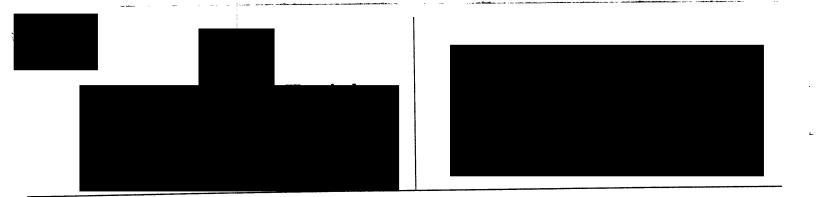
MODERATE GROWTH NORMAL ORAL FLORA ISQLATED

REFERENCE LAB IDENTIFICATION

1920	LUP (DVVT, PLT NEUTRALIZ.)
1920	DILUTE CON (DVVT CONFIRM)
1920	THROMB TIM (THROMBIN TIME)
1745	THROMB TIM (THROMBIN TIME)
1920	PROT C ACT (PROTEIN C ACTIVITY)
1920	PROT C RES (PROTEIN C RESISTANCE (ACT))
1100	NAUR (SODIUM, URINE RANDOM)
0600	FREE PTN (FREE PHENYTOIN)
1920	CARDIO PA (CARDIOLIPIN IGG, CARDIOLIPIN IGM, CARDIOLIPIN IGA)
1825	MHA-TP (MHA-TP)
1825	RPR (R) (RPR)
	HOMOCY PL (HOMOCYSTEINE, PLASMA)
1825	DSI (AMPHETAMINES, BARBITURATES, BENZODIAZEPINES, COCAINE, OPIATES
	PHENCYCLIDINE, TETRAHYDROCANNABINOL)
1745	IGA (TOTAL IGA)
0.001	THE CARE BY AR COREEN CROCCMATCH
	T&C (ABO TYPE, RH, AB SCREEN, CROSSMATCH) T&C (ABO TYPE, RH, AB SCREEN, CROSSMATCH)
	The state of the s
0200	GSH (ABO TYPE, RH, AB SCREEN)
	1920 1920 1745 1920 1920 1100 0600 1920 1825

000119

END OF REPORT



DATE

01/04/99

TIME DAY 1920

MON

PROCEDURE

HOMO NEG

FACTOR 5 LEIDEN COMMENT

FOOTNOTE

000120

REFERENCE RANGE

UNITS

END OF REPORT

DISCHARGE - FINAL MEDICAL RECORDS LABORATORY REPORT



FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/03/99 TIME: 0356

ACCESSION #

REPORT

DATE OF SERVICE: 01/03/99; 0356

PROCEDURE PERFORMED: Head CT.

REFERRING PHYSICIAN:

CLINICAL HISTORY:

This is a 29-year-old here to evaluate cerebral edema.

Seven-millimeter contiguous noncontrast transaxial images were performed through the head and imaged utilizing a bone and soft tissue window.

This patient has had a large right MCA infarct with marked mass effect and attenuation of the right lateral ventricular system, contralateral ventricular dilatation, and shift of the midline. There is some high density noted within the basal ganglia which is high density relative to the ischemic brain but not increased relative to the remaining parenchyma. This would suggest petechial hemorrhage in this location. This was noted on the prior study and is unchanged. There is no large sizable intraparenchymal or interval hemorrhage noted. Once again noted is evidence for high density in the ambient cisterns and location of the middle cerebral arteries bilaterally. This too is stable. The low density within the anterior cerebral distribution on the right is also unchanged.

The only change noted is an area of low density now noted on the left in a parasagittal location seen only on axial image #13. This appears slightly more than would be anticipated for volume averaging of the ventricle immediately below, and therefore it is worrisome that an area of left parafalx anterior cerebral artery distribution ischemia/infarction may be accounting for this appearance.

000121

MEDICAL RECORDS COPY

PAGE : CONTINUED



PATIENT : VISIT # : PMH MRN : ADM MD ADM DATE: PT LOC

FINAL

MRN

DOB SEX

ROOM

CT HEAD WO/CONT

DATE: 01/03/99 TIME: 0356

ACCESSION #

IMPRESSION

IMPRESSION:

1. This patient is status post an acute right MCA territory infarct with marked mass effect and shift of the midline structures. There is also evidence for uncal and tentorial herniation. Overall, these appearances are unchanged compared to the 01/02/99 study.

The only change that has occurred on this study relates to an area of low density on the left in a parasagittal location seen only on one image. Questionable subtle involvement may be seen on the image immediately above. This appears more than accounted for by volume averaging and therefore is worrisome for and could be in keeping with an area of ischemia/infarction related to the left anterior cerebral artery territory.

No interval intracranial hemorrhage or hemorrhagic conversion is

noted.

Dictated by:

M.D.

01/03/99 Job

, M.D.

SIGNED BY: RESIDENT ID: M.D.

T: 04JAN1999 S: 11JAN1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

000122

MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

<u>-</u>-

FORM #:

PATIENT : VISIT # : PMH MRN : DOB ADM MD ADM DATE: PT LOC :

FINAL

MRN

SEX

ROOM

REFERRING PHYSICIAN:

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/03/99

TIME: 1211

ACCESSION #

REPORT

DATE OF SERVICE: 01/03/99; 1211.

PROCEDURE PERFORMED: Chest.

FINDINGS: See Impression.

000123

MEDICAL RECORDS COPY

PAGE: 1 CONTINUED



ADM DATE:

FINAL

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/03/99 TIME: 1211

PMH MRN :

PT LOC ROOM

DOB SEX ADM MD

ACCESSION #

IMPRESSION

IMPRESSION:

FINDINGS:

Single AP portable view of the chest dated 01/03/99 at 1200 is submitted for interpretation without prior studies for comparison. There is an asymmetric density to the lung fields, likely owing to technical factors associated with positioning of the patient relative to the x-ray tube and film cassette. At least hypoventilatory changes contribute to the increased parenchymal density in the right base and some ill definition of the vessels on this side. Early pneumonia in the right base and for mild edematous changes cannot be excluded. The cardiac silhouette size is okay for technique, but again, I do not have prior studies on this patient to establish a true baseline.

Dictated by:

M.D.

D: 01/03/99; 1348

Job

SIGNED BY: RESIDENT ID:

T: 04JAN1999 S: 21JAN1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

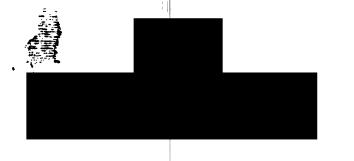
000124

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MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

FORM #:



PATIENT:
MRN:
VISIT #:
PMH MRN:
DOB:
SEX:
ADM MD:
ADM DATE:
PT LOC:
ROOM:

FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/05/99

TIME:

ACCESSION #

0122

REPORT

DATE OF SERVICE: 01/05/99; 0122.

PROCEDURE PERFORMED:

CT head.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

This is a 29-year-old male patient status post right middle cerebral stroke.

السارسيد في

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

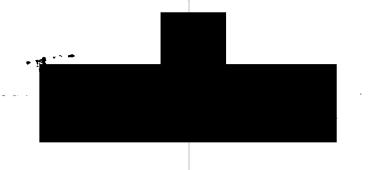
FINDINGS:

A right frontotemporal craniotomy has been performed. There has been removal of parts of the right frontal and temporal lobes. Low density is present in the remaining portions of the right frontal and temporal region. A midline shift towards am unable to accurately ascertain the position of the right medial temporal lobe, which may be impinging on the right lateral aspect of the main stem on images #6 and #7. Moderate enlargement of the left lateral ventricle including the temporal horn, however, the left lateral ventricle is minimally better than on the prior study. There is midline shift towards the left.

000125

MEDICAL RECORDS COPY

PAGE: 1 CONTINUED



PATIENT : MRN VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 01/05/99 TIME: 0122

ACCESSION #

IMPRESSION:

Resection of part of the right frontal and temporal lobes. The left lateral ventricle is slightly improved in appearance. There is continued effacement of basal cisterns and medial temporal lobe impinging on the right lateral aspect of the brain stem. Some intraventricular blood remains present in the occipital horn on the left.

IMPRESSION

Dictated by:

M.D.

01/20/99; 1720

Job

SIGNED BY: RESIDENT ID: M.D.

21JAN1999 S: 21JAN1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

000126

MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

FORM #



PATIENT VISIT # PMH MRN : ADM MD ADM DATE: PT LOC

FINAL

MRN

DOB SEX

ROOM

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE:

01/05/99

TIME: 1534

ACCESSION #

REPORT

DATE OF SERVICE: 01/05/99; 1534.

PROCEDURE PERFORMED:

CT head.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

This is a 29-year-old male patient status post lobectomy for decompression.

و مازماند في

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

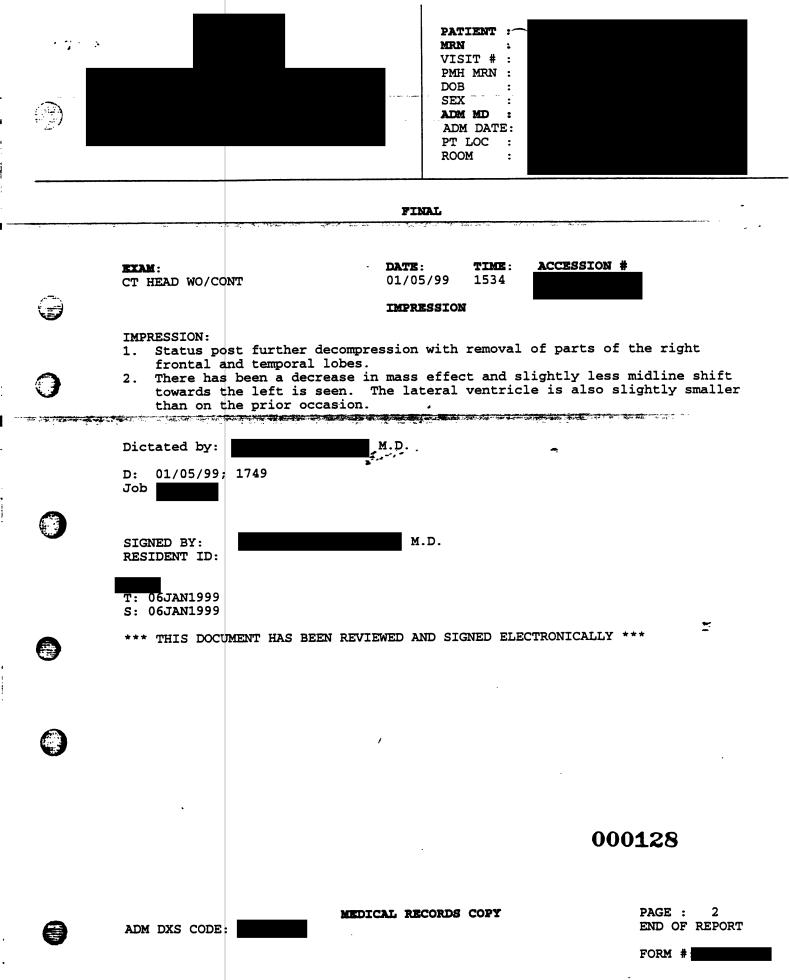
FINDINGS:

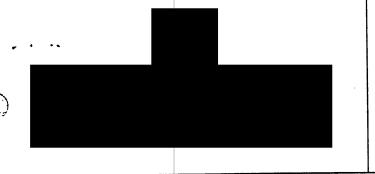
A right front otemporal craniotomy has been performed as previously noted. In the interval since the prior study of 01/04, the patient has undergone further decompression with removal of parts of the right frontal and temporal lobes. Low density changes in the right middle cerebral territory are seen as previously described. There has been a decrease in mass effect. Now currently only a mild degree of midline shift towards the left. The left lateral ventricle is less distended than on the prior occasion. A small amount of blood is seen in the left occipital horn. There is continued effacement of the basal cistern and the position of the medial temporal lobe is difficult to evaluate.

000127

MEDICAL RECORDS COPY

PAGE: CONTINUED





PMH MRN : ADM DATE:

FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/05/99 TIME: 2301

PATIENT MRN VISIT #

PT LOC ROOM

DOB SEX ADM MD

CCESSION #

REPORT

DATE OF SERVICE:

01/05/99; 2301

PROCEDURE PERFORMED:

CT head.

REFERRING PHYSICIAN:

M.D.

This is a 29-year-old male patient status post lobectomy for treatment of The patient is referred for followup evaluation. stroke.

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TECHNIQUE:

Seven-millimeter contiguous axial images were obtained from the skull base through the vertex without the use of intravenous contrast agent. Bone and soft tissue images were obtained.

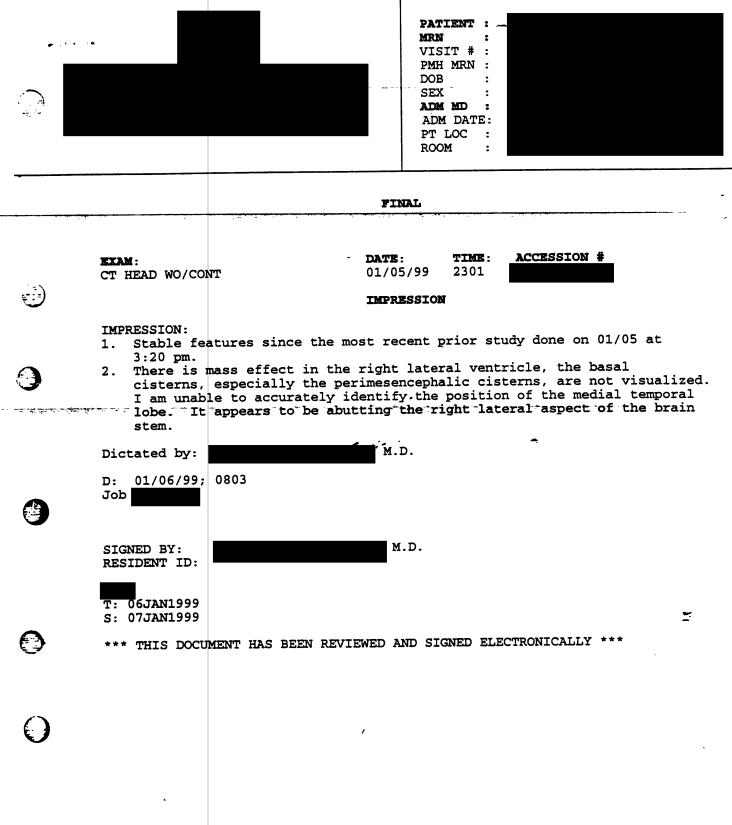
FINDINGS:

As seen previously, a right frontotemporal craniotomy has been performed. There has been removal of part of the right frontal and temporal lobes. Patchy blood is present in the vicinity of the lobectomy. Blood is also present in the ventricles, layering out in the occipital horns. As previously noted, there is some mass effect present with effacement of the right lateral ventricle and effacement of the perimesencephalic cisterns. The appearance of the left lateral ventricle is stable since the earlier study done on 01/05 at 3:20 p.m. No obvious new lesions are seen since the study done earlier on 01/05. There is effacement of sulci bilaterally. There is some extra-axial blood subjacent to the craniotomy which is unchanged in appearance since the prior study.

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MEDICAL RECORDS COPY

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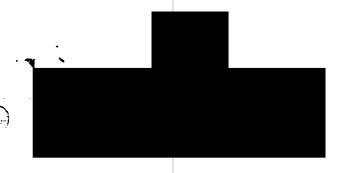


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MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

FORM #



PATIENT : VISIT # : PMH MRN: ADM DATE: PT LOC :

FINAL

DOB SEX ADM MD

ROOM

REFERRING PHYSICIAN:

EXAM:

PORTABLE CHEST X-RAY PORTABLE CHEST X-RAY DATE: 01/05/99 TIME: 1314

0454

ACCESSION #

REPORT

01/05/99

DATE OF SERVICE: 01/05/99; 1314.

PROCEDURE PERFORMED: Chest.

المسترسين في CLINICAL HISTORY: This is a postoperative patient in whom we are asked to rule out pneumonia.

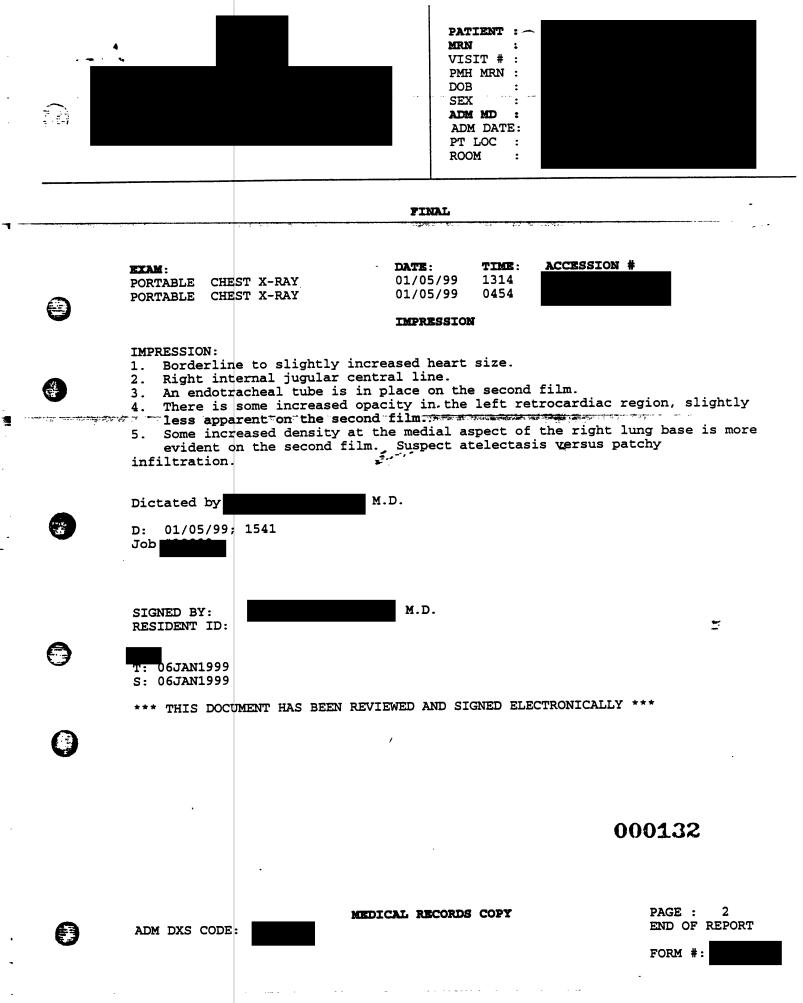
AP portable views of the chest were obtained on 1/5/99 at 0401 and at 1320. The first film demonstrates a right internal jugular central line with the tip in the superior vena cava. The heart size is borderline to minimally increased. There is an increased density in the left retrocardiac region suggesting atelectasis or infiltration. The pulmonary vessels are borderline.

On the 1320 film, an endotracheal tube is seen with the tip at the level of the sternal notch. There is perhaps a little less density in the left retrocardiac region but there is some patchy parenchymal disease in the right infrahilar area.

000131

MEDICAL RECORDS COPY

PAGE : CONTINUED



FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/06/99 TIME: 0958

PATIENT : MRN VISIT # : PMH MRN :

DOB SEX ADM MD ADM DATE: PT LOC ROOM

ACCESSION #

REPORT

DATE OF SERVICE: 01/06/99; 0958.

PROCEDURE PERFORMED: THE RESIDENCE OF THE RESIDENCE OF THE PARTY OF THE PARTY

CT head.

REFERRING PHYSICIAN:

CLINICAL HISTORY:

A 29-year-old male patient status post lobectomy for treatment of stroke.

المراسع والمعالم

Seven mm contiguous axial images were obtained from the skull base to the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

A right front otemporal craniotomy has been performed. There has been partial removal of the right frontal and temporal lobes. There is low density in the right middle cerebral territory. There is mass effect of the right lateral ventricle with near complete effacement. There is more mass effect on the current exam than on the prior study of 01/05 and there is more midline shift towards the left. The degree of midline shift now measures approximately 12 mm. There is enlargement of the left lateral ventricle. The left temporal horn is dilated.

Position of the medial temporal lobe is difficult to determine. It appears that the medial temporal lobe is pressing against the right lateral aspect of the midbrain, best appreciated on images 6 and 7. This causes distortion of the midbrain.

IMPRESSION:

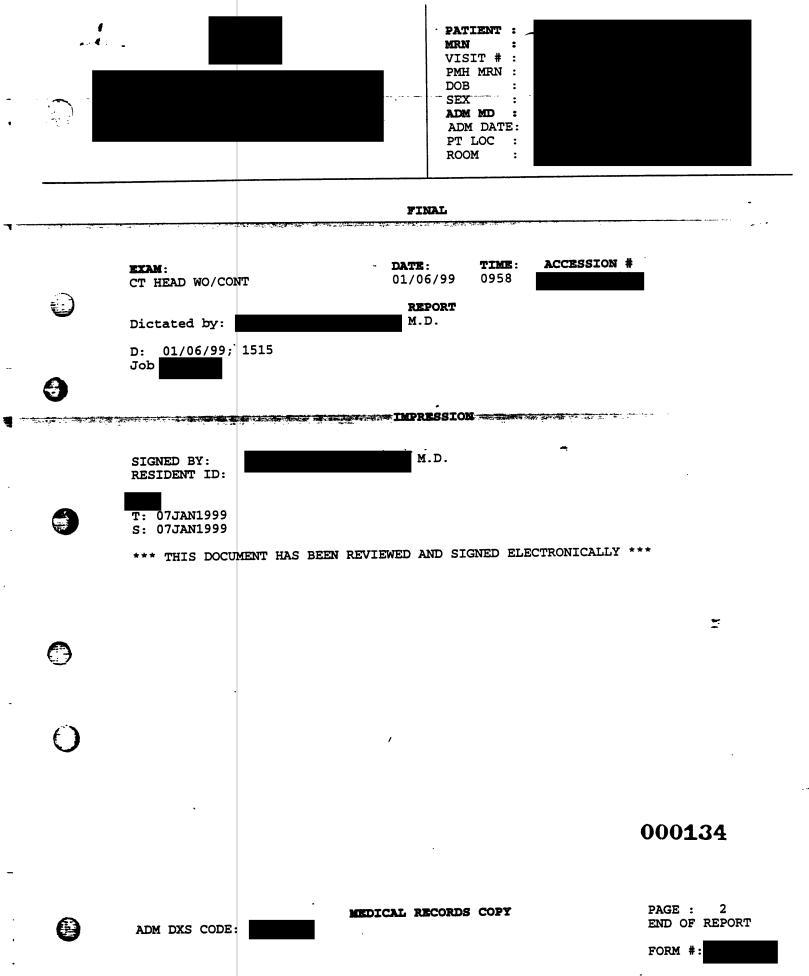
- 1. Interval slight increase in degree of midline shift towards the left.
- 2. Interval slight increase in size of left lateral ventricle.
- 3. Residual blood present in the left occipital horn.

MEDICAL RECORDS COPY

PAGE : CONTINUED

FORM #:

000133



PATIENT MRN VISIT # PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM



FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/06/99 TIME: 1827

THE THE STATE OF THE PROPERTY OF THE PROPERTY

ACCESSION #

REPORT

DATE OF SERVICE: 01/06/99; 1827

PROCEDURE PERFORMED:

CT head.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

This is a 29-year-old male patient status post lobectomy for decompression.

و مزرنده

Seven-millimeter contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

In the interval since the preceding study, the patient has undergone further decompressive surgery. There has been further removal of part of the right hemisphere. Some remaining parenchyma is seen in a parasagittal location high up and close to the convexity. A marker is seen along the posterior margin of the thalamus.

There has been interval return of the midline structures to a central location. The left lateral ventricle is now considerably smaller than on the prior occasion. Some blood is still seen in the left occipital horn. The third ventricle contains blood and is in the midline.

000135

MEDICAL RECORDS COPY

PAGE: CONTINUED

PATIENT : MRN VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC : ROOM FINAL

EXAM:

CT HEAD WO/CONT

DATE: 01/06/99 TIME: 1827

ACCESSION #

IMPRESSION

IMPRESSION:

Status post interval further decompressive surgery since the prior study with return of the central structures to the midline. There has been preservation of the right thalamus and parts of the right posterior frontal lobe. There has been interval decompression of the left lateral ventricle.

Dictated by:

M.D.

<u>01/07/9</u>9; 0906

Job

SIGNED BY: RESIDENT ID:

T: 07JAN1999

S: 07JAN1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

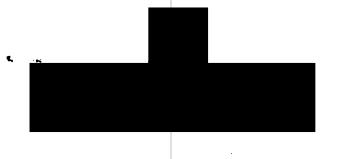
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FORM #:



PATIENT VISIT # PMH MRN ADM MD ADM DATE: PT LOC ROOM

FINAL

DOB SEX

REFERRING PHYSICIAN:

EXAM: MR BRAIN DATE: 01/06/99

TIME: 1150

ACCESSION #

REPORT

CLINICAL HISTORY: Cerebral infarct.

IMAGING PARAMETERS: Sagittal images of the brain were obtained using a T1 weighted sequence pregadolinium infusion. Coronal images of the brain were obtained using a T1 weighted sequence pregadolinium infusion and a T2 weighted sequence. Axial images of the brain were obtained using T1 and T2 weighted sequences. In addition, diffusion weighted imaging technique was performed. 179 slices were acquired.

INTERPRETATION: No previous MRI of the brain is available for comparison.

The patient is status post partial right frontal lobectomy. In its place, there is a fluid collection. There is demonstration of T1 shortening along the surgical margin, consistent with hemorrhage. In addition, posterior to the surgical area, there is an irregular area of T1 shortening seen within the basal ganglia which represents petechial hemorrhage. In addition, there is also demonstration of T2 shortening in this region, also consistent with blood products. Diffusion weighted imaging technique demonstrates acute infarct in the distribution of the right ACA and right MCA. There is relative sparing of the right PCA distribution. This finding is consistent with occlusion of the right internal carotid artery seen to the level of the skull base. There is also demonstration of a small amount of blood within the occipital horn of the left lateral ventricle. There is significant local mass effect within the infarcted region characterized by loss of the cortical sulci. In addition, there is significant mass effect as characterized by effacement of the right lateral ventricle, shift of the midline to the left, and inferior herniation of the posterior fossa structures; i.e,, displacement of the midbrain and cerebellar tonsils inferiorly. There is also loss of the normal basal cistern

The visualized paranasal sinuses are clear. There is some fluid within the right mastoid air cells; the left mastoid air cells are clear.

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EXAM: MR BRAIN DATE:

TIME:

ACCESSION #

01/06/99 1150

IMPRESSION

1. There is occlusion of the right internal carotid artery to the level of the skull base which is associated with infarction of the right ACA and MCA distribution. The patient is status post partial resection of the right frontal lobe. However, there remains significant mass effect characterized by displacement of the midline structures to the left as well as inferior displacement of the posterior fossa structures.

SS#

I personally reviewed the films and the above report and concur.

SIGNED BY: RESIDENT ID:

T: 07JAN1999 S: 25JAN1999

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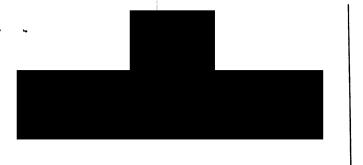
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PAGE: 2 END OF REPORT

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FORM #:



FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/07/99 TIME: 0249

PATIENT MRN VISIT # PMH MRN:

DOB SEX ADM MD ADM DATE: PT LOC ROOM

ACCESSION #

REPORT

DATE OF SERVICE:

01/07/99; 0249

PROCEDURE PERFORMED:

CT head.

REFERRING PHYSICIAN:

CLINICAL HISTORY:

This is a 29-year-old male patient referred for followup evaluation status post multiple decompressive brain surgeries.

TECHNIQUE:

Seven-millimeter contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

As previously seen, much of the right hemisphere has been removed. The zight thalamus and part of the right posterior frontal lobe have been preserved. A marker is seen along the posterior aspect of the thalamus. A surgical cavity is seen in the right frontotemporal location. The midline structures are in a central location. The left lateral ventricle is smaller than on the preceding study. Blood is present in the third ventricle, which is unchanged in size.

000139

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PATIENT : VISIT # : PMH MRN: ADM MD ADM DATE: PT LOC :

FINAL

MRN

DOB SEX

ROOM

EXAM:

CT HEAD WO/CONT

DATE:

TIME: 0249

ACCESSION #

IMPRESSION

01/07/99

IMPRESSION:

Interval decrease in the size of the left lateral ventricle. The remaining features are stable.

Dictated by:

M.D.

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D: 01/07/99;=0908

Job

SIGNED BY:

RESIDENT ID:

M.D.

T: 07JAN1999 S: 07JAN1999

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FORM #:



PMH MRN : ADM DATE:

FINAL

REFERRING PHYSICIAN:

EXAM:

PORTABLE CHEST X-RAY PORTABLE CHEST X-RAY

TIME: DATE: 01/06/99

1651 01/07/99 0441

PATIENT MRN VISIT #

PT LOC ROOM

DOB SEX ADM MD

ACCESSION #

REPORT

DATE OF SERVICE: 01/06/99, 01/07/99.

PROCEDURE PERFORMED:

Portable chest x-ray.

مرسومي CLINICAL HISTORY: This is a 29-year-old man who is said to be postoperative. We are asked to assess pneumonia.

FINDINGS:

AP portable views of the chest were obtained on 01/06/99 at 1630 and on 01/07/99 at 0421. There is a previous film for comparison dated 01/06/99 at

An endotracheal tube, right internal jugular central line, and nasogastric tube remain in place. The tip of the nasogastric tube is believed to be high in the stomach. On the 01/06/99 at 1630 film, there is some increased density at the medial aspect of the right lung base suggesting atelectasis. The right lateral costophrenic angle is not very sharply defined. The inspiratory effort is better on the second film and the right lung base appears relatively clear. The right lateral costophrenic angle is sharply defined. On this film, there is increased density in the left retrocardiac region which is suspicious for left lower lobe atelectasis.

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PATIENT : VISIT # : PMH MRN: ADM DATE: PT LOC :

FINAL

EXAM:

PORTABLE CHEST X-RAY PORTABLE CHEST X-RAY

TIME: DATE: 01/06/99

MRN

DOB SEX ADM MD

ROOM

1651 0441 ACCESSION #

IMPRESSION

01/07/99

IMPRESSION:

- 1. The right lung base appears a little worse on the 01/06/99 at 1630 as compared with the 01/06/99 at 0422 film, and the findings are suspicious for atelectasis and possibly some pleural fluid. The right chest appears much better on the 01/07/99 film, but there is increased opacity in the left retrocardiac region on that film suspicious for lower lobe atelectasis.
 - Nasogastric tube with tip high in stomach.
 - 3. Endotracheal tube and right internal jugular central line are unchanged.

Dictated by:

M.D.

D: 01/07/99; 1522

Job |

SIGNED BY: RESIDENT ID: M.D.

: 07JAN1999

S: 11JAN1999

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PATIENT : MRN VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

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REFERRING PHYSICIAN:

DATE: 01/08/99

مرسورتي

TIME: 0319

ACCESSION #

REPORT

DATE OF SERVICE: 01/08/99, 0319.

CT HEAD WO/CONT

EXAM:

PROCEDURE PERFORMED: CT of head.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

A 29-year-old male patient status post large middle cerebral territory stroke.

Seven millimeter contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

The current study is compared to the most recent prior study done on 01/07. As seen on that study, much of the right hemisphere has been removed. Air is present in the right frontal region within a large cavity. Fluid/encephalomalacia is seen more posteriorly. Some preserved parenchyma is seen in the right posterior frontal region and in the region of the thalami. A marker is seen along the posterior aspect of the right thalamus. Intraventricular blood is present and is best seen in the occipital horns. The left lateral ventricle is within a normal size range. The third ventricle is in the midline and contains some blood. These features are not significantly different than that seen on 01/07.

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EXAM:

CT HEAD WO/CONT

DATE: 01/08/99

TIME: 0319

ACCESSION #

IMPRESSION

M.D.

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IMPRESSION:

Interval stability since 01/07.

Dictated by Dr.

D: 01/08/99 0849

Job

SIGNED BY: RESIDENT ID:

T: 08JAN1999

S: 08JAN1999

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PATIENT : MRN VISIT # PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

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REFERRING PHYSICIAN:

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/08/99 TIME: 0442

The state of the s

ACCESSION #

REPORT

DATE OF SERVICE: 01/08/99

PROCEDURE PERFORMED: Portable chest x-ray.

CLINICAL HISTORY: This is a 29-year-old man who is said to have pneumonia.

FINDINGS:

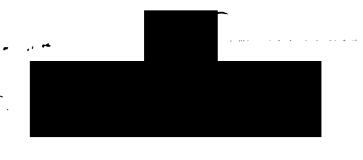
An AP portable view of the chest was obtained on 01/08/99 at 0350.

Compared with prior film of 01/07/99 at 0421, not much interval change is seen. There is increased opacity in the left retrocardiac region which would be consistent with atelectasis or infiltration. The pulmonary vessels are borderline. The endotracheal tube, nasogastric tube, and right internal jugular central line are unchanged.

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MEDICAL RECORDS COPY

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PATIENT : MRN VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

PORTABLE CHEST X-RAY

DATE:

01/08/99

TIME:

ACCESSION #

0442

IMPRESSION

IMPRESSION:

Tubes and lines are unchanged.
 Persistent density, left retrocardiac region, consistent with atelectasis

and/or pneumonia.

Dictated by:

M.D.

D: 01/08/99; 1324

A. - 1 - 1

SIGNED BY:

M.D.

RESIDENT ID:

T: 08JAN1999 S: 11JAN1999

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FORM #:



PATIENT : VISIT # : PMH MRN : ADM MD ADM DATE: PT LOC

FINAL

REFERRING PHYSICIAN:

EXAM: SONO, EXTREM VEIN UNIL DUP DATE: TIME: 01/08/99 0822

MRN

DOB SEX

ROOM

ACCESSION #

REPORT

DATE OF SERVICE: 01/08/99

PROCEDURE PERFORMED:

Acceptable Lower extremity sonogram with Doppler

CLINICAL HISTORY:

The patient is being evaluated for development of DVT while at long-term bedrest for neurosurgical indication.

FINDINGS:

Discussion: Doppler percussion ultrasound was performed in the ICU from the level of the common femoral through the popliteal veins bilaterally. Normal incremental compression, respiratory variation, and augmentation was noted.

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MEDICAL RECORDS COPY

PAGE : CONTINUED

PATIENT : VISIT # : PMH MRN: ADM DATE: PT LOC :

FINAL

DOB SEX ADM MD

ROOM

EXAM:

SONO, EXTREM VEIN UNIL DUP

DATE: 01/08/99 TIME: 0822

ACCESSION #

IMPRESSION

IMPRESSION:

No evidence for DVT from the level of the common femoral through the popliteal regions bilaterally.

Dictated by:

M.D.

D: 0<u>1/08/9</u>9; 1022

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SIGNED BY:

RESIDENT ID:

M.D.

T: U8JAN1999 S: 08JAN1999

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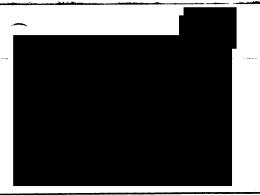
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PATIENT : MRN VISIT # PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM



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REFERRING PHYSICIAN:

DATE:

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TIME: 0405

ACCESSION #

REPORT

01/09/99

DATE OF SERVICE: 01/09/99; 0405.

CT HEAD WO/CONT

PROCEDURE PERFORMED:

CT head.

EXAM:

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

A 29-year-old male for follow-up of resection of infarcted tissue in the right hemisphere.

TECHNIQUE:

Serial axial images are obtained of the head from the level of the foramen magnum to the vertex without the use of an intravenous contrast agent. Bone windows are obtained as well.

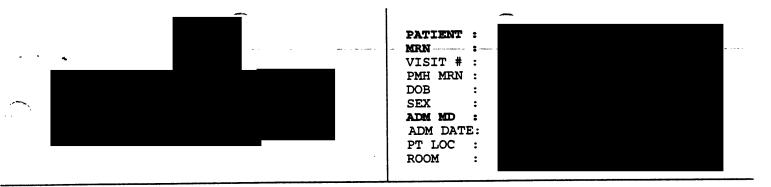
FINDINGS:

Comparison is made to most recent exam of 01708/99. As before, the patient is most recently status post extensive resection of portions of the right cerebral hemisphere, the area of hemorrhagic infarction. Markedly enlarged CSF space is now present with residual hemorrhage along the operative site with remnant of basal ganglia and parasagittal portion of the right hemisphere remaining. Large extracranial fluid collection is seen mixed with air. Pneumocephalus is again present but somewhat less prominent than on the prior exam. Ventricular size appears stable with asymmetric enlargement of the left lateral ventricle and blood layering the occipital horn as well as in the third ventricle. Drainage catheter is again seen in place on the right.

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MEDICAL RECORDS COPY

PAGE: CONTINUED



FINAL

EXAM:

CT HEAD WO/CONT

- DATE: 01/09/99 TIME: 0405

ACCESSION #

IMPRESSION

IMPRESSION:

1. Status post extensive resection of right hemisphere with interval decrease in pneumocephalus since the prior study of 01/08/99.

2. Stable ventricular size with interventricular hemorrhage again noted.

No evidence for interval hemorrhage or new low density region is identified.

Dictated by:

01/09/99; 0742

Job

M.D.

SIGNED BY: RESIDENT ID:

T: 11JAN1999

S: 12JAN1999

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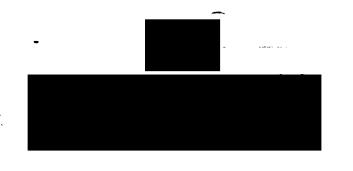
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3	EXAM: PORTABLE CHEST X-RAY	DATE: 01/09/99	TIME: 0523	ACCESSION #		
		REPORT				
9	DATE OF SERVICE: 01/09/99; 0523					
	PROCEDURE PERFORMED: Portable chest x-ray.	.·				
A	FINDINGS: Portable chest film dated in the cardiomegaly and ap and catheters are unchange There is no new consolidat	pearance of the d. Consolidated	mediasti l left lo	num. The position wer lobe is unchan	of tubes	
		IMPRESSIO	N			
	<pre>IMPRESSION: Left lower lobe pneumonia/</pre>	atelectasis unch	nanged.			
	Dictated by: M.D.					
	D: 01/09/99; 1137 Job#					
0	SIGNED BY: RESIDENT ID:	M.D.				
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PATIENT : MRN VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM



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REFERRING PHYSICIAN:

DATE: 01/09/99

TIME: 1622

1322

ACCESSION #

REPORT

01/09/99

DATE OF SERVICE:

01/09/99.

ABDOMEN AP

ABDOMEN AP

EXAM:

PROCEDURE PERFORMED:

Abdomen.

CLINICAL HISTORY:

This is a 29-year-old man who has had placement of a feeding tube.

FINDINGS:

AP supine portable views of the abdomen were obtained on 01/09/99 at 1220 and at 1515. The pelvis is not included on either film. On the first film, a feeding tube is seen with the tip near the esophagogastric junction. The second film shows that the feeding tube has been advanced into the stomach. It is bent slightly and the tip lies high in the stomach. There is gas throughout the colon. On the first film, an artifact overlies the right lower abdomen obliquely across the right side of L5 and the upper sacrum. This area is not included on the second film. A STATE OF THE PARTY OF THE PAR

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PATIENT : MRN VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC : ROOM

FINAL

EXAM:

ABDOMEN AP ABDOMEN AP DATE: 01/09/99

01/09/99

TIME: 1622

1322

ACCESSION #

IMPRESSION

IMPRESSION:

- 1. A feeding tube was first noted to be in the esophagus with the tip near the esophagogastric junction. It was then advanced into the upper stomach.
- 2. Bowel gas pattern nonspecific, nonobstructive.
- 3. An artifact overlies the right lower abdomen on the first film. It is not seen on the second film but this could be due to film positioning - please correlate with clinical findings regarding its etiology.

Dictated by Dr.

01/11/99, 1051 D:

Job

M.D.

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SIGNED BY: RESIDENT ID:

11**JAN199**9 S: 11JAN1999

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PATIENT : MRN : VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC : ROOM



FINAL

REFERRING PHYSICIAN:

TIME: DATE: EXAM: 01/09/99 1322 PORTABLE CHEST X-RAY 0725 01/10/99 PORTABLE CHEST X-RAY 0605 01/11/99 PORTABLE CHEST X-RAY

ACCESSION #

REPORT

DATE OF SERVICE: 01/09/99, 01/10/99, and 01/11/99.

PROCEDURE PERFORMED:

Chest.

CLINICAL HISTORY:

This is a 29-year-old man in whom we are asked to evaluate lines as well as possible infiltrates.

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FINDINGS: AP portable views of the chest were obtained on 01/09/99 at 1228, 01/10/99 at 0725, and on 01/11/99 at 0537. There is a previous film for comparison dated 01/09/99, 0458. There is an endotracheal tube with the tip above the level of the sternal notch on the first two films. It was removed prior to the third film. A feeding tube with the tip fairly high in the stomach was also present on the first two films but removed prior to the third film. A right subclavian central line is in place on all three films. On the first film, a right internal jugular line was also present, which was removed prior to the film of 01/10/99. On the first film, there is some increased density in the left retrocardiac region and a little patchy parenchymal disease at the right base. The right base appears to have improved on the next two films. There is perhaps still a little increased density in the left retrocardiac region.

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MEDICAL RECORDS COPY

PAGE: CONTINUED

PATIENT : MRN --- : VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

DATE: ACCESSION # TIME: EXAM: 01/09/99 1322 PORTABLE CHEST X-RAY 0725 PORTABLE CHEST X-RAY 01/10/99 0605 PORTABLE CHEST X-RAY 01/11/99

IMPRESSION

IMPRESSION:

- The endotracheal tube, feeding tube, and right internal jugular central line were removed. There is a new right subclavian central line in good position with no evidence of pneumothorax.
- 2. Some patchy parenchymal changes at the right base have cleared over the three film series. There is believed to be a little less density in the left retrocardiac region, although some is believed to persist.

Dictated by Dr.

D: <u>01/11/99</u> 1048

Job

SIGNED BY: RESIDENT ID: M.D.

11JAN1999 S: 11JAN1999

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FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/10/99 TIME: 0408

ACCESSION #

REPORT

DATE OF SERVICE: 01/10/99; 0408.

PROCEDURE PERFORMED: CT head.

REFERRING PHYSICIAN: M.D.

CLINICAL HISTORY:

A 29-year-old male status post resection of extensive cerebral hemorrhagic infarct for follow-up.

£

TECHNIOUE:

Serial axial images are obtained of the head from the level of the foramen magnum to the vertex without the use of an intravenous contrast agent. Bone windows are obtained as well.

FINDINGS:

Comparison made to prior study of 1/9/99. As before, the patient is recently status post resection of an extensive right hemispheric hemorrhagic infarct. Vast portions of a right basal ganglia remain as well as small portion of the frontoparietal lobe parasagittally. Blood is again seen around the resection site and there is blood, CSF level on the right as well as blood layering in the occipital horns bilaterally and is present in the anterior third ventricle. There continues to be mild right to left midline shift with effacement of the right lateral ventricle. No evidence for hydrocephalus or change in ventricular size is seen. No evidence for interval hemorrhage or new area of low density is noted. Low density is again seen, however, unchanged in appearance in the posterior limb of the internal capsule on the right. The amount of pneumocephalus and extracranial air is not significantly changed.

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EXAM:

CT HEAD WO/CONT

DATE:

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ACCESSION #

01/10/99 0408

IMPRESSION

IMPRESSION:

Overall stable appearance without significant change seen since the prior study of 1/9/99 as described above.

Dictated by

M.D

D: <u>01/10/9</u>9; 0727

Job

2000

SIGNED BY: RESIDENT ID:

M.D

T: 110AN1999 S: 19JAN1999

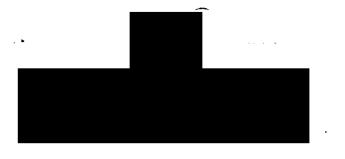
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FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/11/99

TIME: 0408

ACCESSION #

REPORT

DATE OF SERVICE:

01/11/99

PROCEDURE PERFORMED:

CT head without contrast.

CLINICAL HISTORY:

This is a 29-year-old male patient status post right middle cerebral artery infarction.

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

As seen previously, there has been removal of a large part of the right hemisphere. The right thalamus and part of the right posterior fossa lobe have been preserved. A blood-fluid-air level is seen in the right half of the cranial cavity. This is unchanged since the prior study. There is slight midline shift toward the left, also unchanged since 01/10. Some intraventricular blood remains evident in the left occipital horn. There is slight interval enlargement of the left temporal horn as compared with the prior study. The third ventricle is not completely seen on this study. No obvious new lesions are demonstrated.

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MEDICAL RECORDS COPY

PAGE: 1 CONTINUED

PATIENT : MRN : VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 01/11/99 TIME: 0408

ACCESSION #

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IMPRESSION

IMPRESSION:

In the interval since 01/10, there has been a slight increase in the size of the left temporal horn. The remaining features are essentially stable.

Dictated by:

M.D.

D: 01/11/99; 1319

Job

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SIGNED BY: RESIDENT ID: M.D.

M1999 s: 13JAN1999

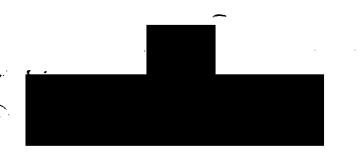
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PATIENT : MRN VISIT # PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM



FINAL

REFERRING PHYSICIAN:

EXAM: ABDOMEN AP

DATE: TIME: 2021 01/11/99 1628 01/11/99 01/11/99 2020

ACCESSION #

REPORT

DATE OF SERVICE: 01/11/99.

PROCEDURE PERFORMED: Abdomen.

CLINICAL HISTORY:

This is a 29-year-old man who has had insertion of a Dobbhoff tube.

FINDINGS:

ABDOMEN AP

ABDOMEN AP

AP supine portable views of the abdomen were obtained on 01/11/99 at 1555, 1950 and at 2009. The lower portion of the pelvis is not included on any of these films. A Dobbhoff tube is in place on all three films. On the first film, the tip lies in the stomach. On the second film the tip could be either in the distal stomach or duodenum. The tip is in the same position on the third film. There is a little gas in the stomach and gas is seen in the colon. Some strandy parenchymal disease is questioned in the left retrocardiac region.

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MEDICAL RECORDS COPY

PAGE: CONTINUED



PATIENT : MRN - --- : -VISIT # : PMH MRN: DOB SEX ADM MD : ADM DATE: PT LOC : ROOM

FINAL

EXAM: ABDOMEN AP ABDOMEN AP ABDOMEN AP

TIME: DATE: 01/11/99 2021 1628 01/11/99 01/11/99 2020

ACCESSION #

IMPRESSION

IMPRESSION:

Dobbhoff tube. The position of the tube has changed between the initial film of this series and the last film. On the last film, the tip is either curled in the antrum or in the duodenum.

Dictated by Dr.

D: 01/12/99 1507

Job |

SIGNED BY: RESIDENT ID: M.D.

T: 12JAN1999

S: 12JAN1999

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FORM #:



PATIENT : MRN . VISIT # PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM



FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/12/99 TIME: 0351

ACCESSION #

REPORT

DATE OF SERVICE:

01/12/99

PROCEDURE PERFORMED:

CT head without contrast.

CLINICAL HISTORY:

This is a 29-year-old male patient status post resection of much of the right hemisphere for treatment of stroke.

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

As seen on the study of 01/11, much of the right hemisphere has been removed for decompression of stroke. Parts of the right posterior frontal lobe and the right thalamus have been preserved. There is some blood adjacent to these structures which is largely unchanged since the prior study. Mild midline shift toward the left is seen. There is some blood in the left occipital horn. The left temporal horn is smaller than on the prior occasion. There is some extra-axial fluid subjacent to the craniotomy. There is also some fluid in the scalp overlying the craniotomy. This is smaller than on the prior

000162

MEDICAL RECORDS COPY

PAGE: CONTINUED

PATIENT : MRN _ : VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 01/12/99 TIME: 0351

ACCESSION #

IMPRESSION

IMPRESSION:

Interval improvement in the size of the left lateral ventricle. The remaining features are stable.

Dictated by:

M.D.

D: 01/12/99; 0929

Job

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SIGNED BY: RESIDENT ID: M.D.

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FINAL

REFERRING PHYSICIAN:

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/12/99

TIME: 0352

ACCESSION #

REPORT

DATE OF SERVICE:

01/12/99

PROCEDURE PERFORMED: Portable chest x-ray.

CLINICAL HISTORY:

This is a 29-year-old man who is said to have pneumonia.

FINDINGS:

An AP portable view of the chest was obtained on 01/12/99 at 0422.

The right subclavian central line is unchanged comparing the film of 01/11/99. There is a new feeding tube coursing through the esophagus and past the lower film margin. The transverse cardiac dimension appears slightly increased. There is minimal elevation of the right diaphragm. The pulmonary vessels are borderline and there is a little increased density in the left retrocardiac region which would be consistent with atelectasis or infiltration.

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MEDICAL RECORDS COPY

PAGE: 1 CONTINUED



PATIENT : MRN ----: VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC : ROOM

FINAL

EXAM:

PORTABLE CHEST X-RAY

DATE:

TIME:

ACCESSION #

0352 01/12/99

IMPRESSION

IMPRESSION:

1. New Dobbhoff tube.

2. Borderline pulmonary vessels.

3. Central line unchanged.

There is a little increased density in the left retrocardiac region suggesting atelectasis or infiltration.

Dictated by:

M.D.

D: 01/12/99; 1517

Job

SIGNED BY: RESIDENT ID: M.D.

S: 12JAN1999

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PATIENT : MRN VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 01/13/99 TIME: 0316

ACCESSION #

REPORT

DATE OF SERVICE: 01/13/99; 0316.

PROCEDURE PERFORMED: CT head.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

A 29-year-old male patient with a stroke who is now status post compressive surgery.

سرب درجي

TECHNIQUE:

Seven mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

As seen on the study of 01/12, an extensive resection procedure has beenperformed with removal of much of the right hemisphere. Parts of the right posterior frontal lobe have been preserved. The right thalamus has been preserved. An outer loculated compartment is smaller than on the prior study. A scalp collection is also present overlying the craniotomy.

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PATIENT : MRN - --- : --VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC : ROOM

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 01/13/99 TIME: 0316

ACCESSION #

IMPRESSION

IMPRESSION:

Interval decrease in the size of an outer loculation of the fluid collection in the right hemisphere. The remaining features are essentially stable. Slight midline shift towards the left as previously seen and the basal cisterns remain attenuated.

Dictated by:

M.D.

2000

D: 01/20/99; 1710

Job

SIGNED BY:

M.D.

RESIDENT ID:

T: 21JAN1999 S: 21JAN1999

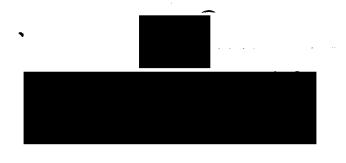
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FORM #



PATIENT : MRN ... : VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

0345



FINAL

REFERRING PHYSICIAN:

DATE: 01/13/99

ACCESSION # TIME :

PORTABLE CHEST X-RAY

REPORT

DATE OF SERVICE: 01/13/99, 0345.

PROCEDURE PERFORMED:

Chest x-ray.

EXAM:

CLINICAL HISTORY:

This is a 29-year-old man who is said to have pneumonia.

FINDINGS:

An AP portable view of the chest was obtained on 01/13/99 at 0410. This film is compared with a prior film of 01/12/99. The technique varies considerably. There is still some increased density with strandy parenchymal changes in the left retrocardiac region, consistent with pneumonia or atelectasis. The right subclavian central line is unchanged. The feeding tube is no longer seen and it presumably has been removed.

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PATIENT : MRN VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/13/99 TIME: 0345

ACCESSION #

IMPRESSION

IMPRESSION:

1. The feeding tube has been removed.

2. Central line unchanged.

3. There is still some strandy increased density in the left retrocardiac region, atelectasis versus infiltration.

Dictated by Dr.

D: 01/13/99, 1442

Job

SIGNED BY: RESIDENT ID: M.D.

T: 13JAN1999

S: 14JAN1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

EXAM:

PORTABLE KUB

DATE:

TIME: 0345

ACCESSION #

REPORT

01/13/99

DATE OF SERVICE:

01/13/99, 0345.

000169

PROCEDURE PERFORMED:

Abdomen.

CLINICAL HISTORY:

This is a 29-year-old man with abdominal distention who has also had replacement of a feeding tube which we are asked to evaluate.

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PATIENT : MRN --- : VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

PORTABLE KUB

DATE: 01/13/99 TIME: 0345

ACCESSION #

REPORT

FINDINGS:

An AP supine portable view of the abdomen was obtained on 01/13/99 at 0410. The Dobbhoff tube tip is seen in the stomach overlying the midline. There is a left pelvic calcification, consistent with a phlebolith. A normal amount of gas is seen throughout the colon. There are one or two loops of gas-containing bowel in the left upper quadrant.

IMPRESSION

IMPRESSION:

1. Dobbhoff tube with tip in the stomach near the midline.

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2. Normal bowel gas pattern.

Dictated by Dr.

D: 01/13/99, 1444 .

Job

M.D.

SIGNED BY: RESIDENT ID:

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FINAL

REFERRING PHYSICIAN:

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/14/99 TIME: 0457

ACCESSION #

REPORT

DATE OF SERVICE: 01/14/99

PROCEDURE PERFORMED: Portable chest x-ray.

CLINICAL HISTORY:

This is a 29-year-old man who is said to have pneumonia.

FINDINGS:

An AP portable view of the chest was obtained on 01/14/99 at 0355.

The heart appears slightly enlarged and the right diaphragm is minimally elevated. There is increased density in the left retrocardiac region consistent with atelectasis or infiltration. In addition, there are diffusely prominent pulmonary vessels suspicious for mild volume overload / congestive heart failure - please correlate with clinical findings. There is a right subclavian central line with the tip in the superior vena cava.

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PATIENT : MRN VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM FINAL

EXAM:

PORTABLE CHEST X-RAY

DATE: 01/14/99 TIME: 0457

ACCESSION #

IMPRESSION

IMPRESSION:

1. Right-sided central line, unchanged.

2. Borderline heart size.

3. Parenchymal disease is seen in the left retrocardiac region - atelectasis versus infiltration.

 The pulmonary vessels appear a little prominent diffusely and I am suspicious of volume overload / congestive heart failure - please correlate with clinical findings.

Dictated by:

سرسريج M.D.

D: 01/14/99; 1532

Job

SIGNED BY:

RESIDENT ID:

M.D.

T: 14JAN1999 S: 18JAN1999

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PORTABLE KUB

DATE: 01/14/99 TIME: 0457

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REPORT

DATE OF SERVICE:

- 01/14/99-

PROCEDURE PERFORMED:

Portable abdomen.

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PATIENT : MRN: .. VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

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EXAM:

PORTABLE KUB

DATE:

TIME: 0457

ACCESSION #

REPORT

01/14/99

CLINICAL HISTORY:

This is a 29-year-old man with a Dobbhoff tube.

FINDINGS:

An AP supine portable view of the abdomen was obtained on 01/14/99 at 0355.

There is a phlebolith in the left pelvis. The bowel gas pattern is normal. The tip of the Dobbhoff tube is seen overlying the midline presumably within the stomach. There is a transitional segment at the thoracolumbar junction. A small tube-like structure is seen overlying the right upper quadrant. I suspect this is outside the patient. I recommend correlation with clinical findings. Some strandy parenchymal changes are believed present in the left retrocardiac region.

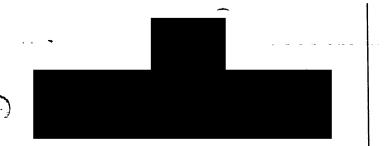
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EXAM:

PORTABLE KUB

DATE: 01/14/99

TIME: 0457

ACCESSION #

IMPRESSION

IMPRESSION:

1. Dobbhoff tube with tip in the stomach overlying the midline.

2. A small tubular density overlying the right upper quadrant has not been seen previously and is quite likely outside the patient - recommend correlation with clinical findings.

3. Normal bowel gas pattern.

4. Strandy parenchymal changes are seen at the left base.

Dictated by:

D: 01/14/99; 1529

Job

r.D.

SIGNED BY: RESIDENT ID:

M.D.

T: 14JAN1999

S: 18JAN1999

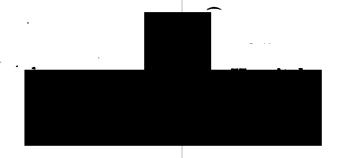
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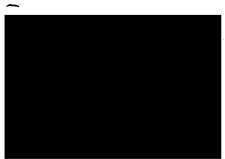
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FINAL

REFERRING PHYSICIAN:

TIME: 0438

ACCESSION #

REPORT

01/15/99

DATE:

DATE OF SERVICE: 01/15/99

CT HEAD WO/CONT

EXAM:

PROCEDURE PERFORMED:
CT head without contrast.

CLINICAL HISTORY:

This is a 29-year-old male patient status post resection of much of the right hemisphere for treatment of stroke.

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

A right frontal and frontotemporal craniotomy have been performed. Parietal craniotomy has also been performed. There has been resection of much of the right hemisphere. Parts of the frontal lobe have been preserved, as has the right thalamus. Some low density is present in the genu of the corpus callosum. There is minimal midline shift toward the right. Low density is present in the region of the posterior limb of the internal capsule. There is no hydrocephalus. Some interventricular blood remains evident in the occipital horn. Air is present in the anterior portion of the right cranial cavity. A soft tissue scalp collection is seen overlying the frontal craniotomy site.

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MEDICAL RECORDS COPY

PAGE: 1 CONTINUED



PATIENT : MRN ----: VISIT # : PMH MRN : DOB SEX ADM MD : ADM DATE: PT LOC : ROOM

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 01/15/99 TIME: 0438

ACCESSION #

IMPRESSION

IMPRESSION:

No significant change since the prior examination. There is no indication of developing hydrocephalus.

Dictated by:

M.D.

D: 01/15/99; 0930

Job

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SIGNED BY:

RESIDENT ID:

M.D.

T: 15JAN1999

S: 19JAN1999

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FORM #:

PATIENT : MRN VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM



FINAL

REFERRING PHYSICIAN:

EXAM: PORTABLE CHEST X-RAY DATE: 01/15/99 TIME: 0437

ACCESSION #

REPORT

DATE OF SERVICE: 01/15/99; 0437.

PROCEDURE PERFORMED:

Chest.

CLINICAL HISTORY:

Pneumonia.

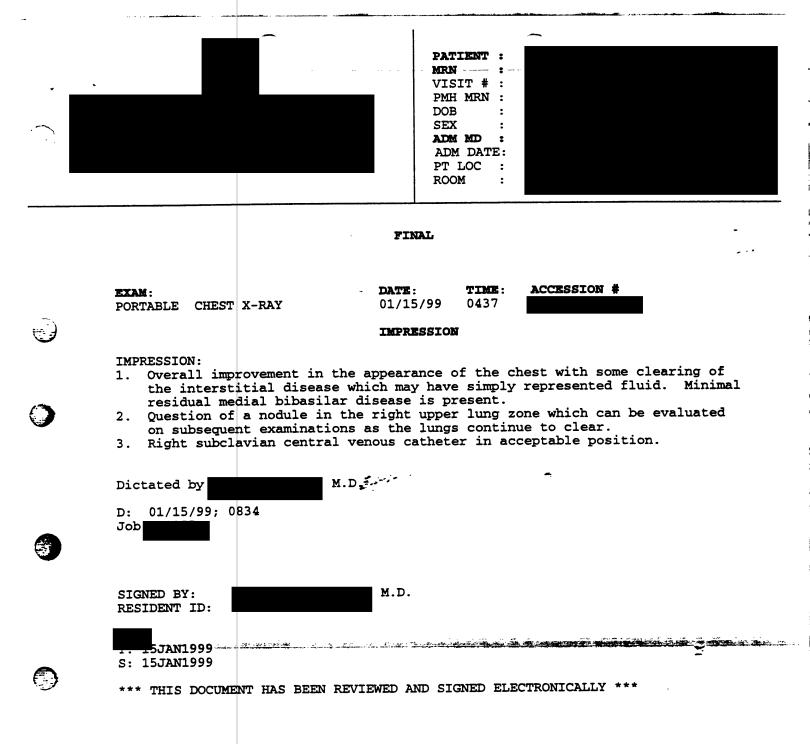
FINDINGS:

Single portable view of the chest dated 01/15/99 at 0415 hours is submitted for interpretation. If anything, I think the patient has improved since the earlier study with some clearing of some of what have simply represented volume overload. Some minimal streaky changes are seen in the bases. A small nodular opacity overlies the posterior right sixth rib. Unfortunately, on many other examinations in this vicinity, the cardiac monitor lead was in this region. This may simply represent a fortuitous artifact or vessel. Certainly, as the patient's lungs are clear, if anything is underlying, this would become more evident and could be evaluated on a subsequent film. The right subclavian line is in the distal SVC with no pneumothorax appreciated. I do not believe pleural fluid to present.

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MEDICAL RECORDS COPY

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MEDICAL RECORDS COPY

PAGE: 2
END OF REPORT

FORM #:

PATIENT : MRN VISIT # PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC



FINAL

ROOM

REFERRING PHYSICIAN:

DATE: 01/16/99 TIME: 0228

ACCESSION #

REPORT

DATE OF SERVICE: 01/16/99; 0228

CT HEAD WO/CONT

PROCEDURE PERFORMED:

CT head.

EXAM:

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:

This is a patient with recent surgical procedure of the brain and agitation.

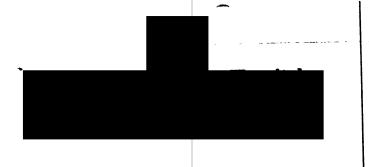
FINDINGS:

The study of 01/16/99 is submitted without prior studies available for comparison. The patient has undergone a recent right frontal craniotomy with a moderately prominent amount of pneumocephalus which may have increased slightly since the previous study. A large-volume right frontal and temporal lobectomy was performed with cerebrospinal fluid occupying that space as well as a ventriculostomy tube traversing it. A band of tissue, presumably the dura, traverses this fluid-filled space, dividing it into two separate fluid cavities. It is marked by some nodularity and high density indicating probable hemorrhagic change associated there. There is shift of midline structures from right to left to a mild degree. Edema in the internal capsule is associated on the right. The left cerebrum appears unremarkable.

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MEDICAL RECORDS COPY

PAGE: CONTINUED



PATIENT : MRN --- :-VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC : ROOM

FINAL

EXAM:

CT HEAD WO/CONT

- DATE: 01/16/99 TIME: 0228

ACCESSION #

IMPRESSION

IMPRESSION:

Status post large-volume lobectomy as described above.

Dictated by:

M.D.

D: _01/16/99; 1313

Job

SIGNED BY:

RESIDENT ID:

M.D.

r: 18JAN1999

S: 19JAN1999

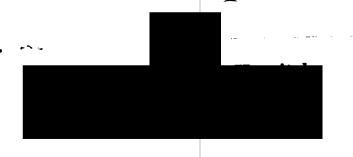
*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

000180

MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

FORM #:



PATIENT : MRN VISIT # PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

REFERRING PHYSICIAN:

EXAM: PORTABLE CHEST X-RAY PORTABLE CHEST X-RAY

TIME: DATE: 0541 01/18/99 1606 01/17/99

ACCESSION #

REPORT

DATE OF SERVICE: 01/17/99, 01/18/99.

PROCEDURE PERFORMED: Portable chest.

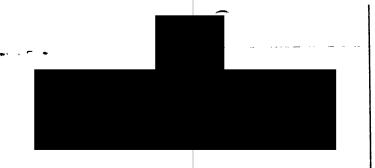
This is a 29-year-old man in whom we are asked to evaluate pneumonia and tube CLINICAL HISTORY: placement.

The heart size is within normal limits. The right lung is clear. There is increased density in the left retrocardiac region consistent with atelectasis or infiltration. A feeding tube can be seen overlying the upper esophagus and airway. There is what appears to be a right sided ventriculoperitoneal shunt overlying the right neck and medial chest descending over the lower dorsal spine.

000181

MEDICAL RECORDS COPY

PAGE: CONTINUED



PATIENT : MRN ---- : VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

PORTABLE CHEST X-RAY

PORTABLE CHEST X-RAY

DATE: 01/18/99

01/17/99

TIME: 0541

1606

ACCESSION #

IMPRESSION

CONCLUSION:

Left retrocardiac parenchymal disease - atelectasis versus infiltration.
 Right sided ventriculoperitoneal shunt line.

3. Feeding tube.

Dictated by:

M.D. Barbara .

D: <u>01/18/9</u>9; 1600

Job

SIGNED BY:

RESIDENT ID:

M.D.

T: 19JAN1999 S: 19JAN1999

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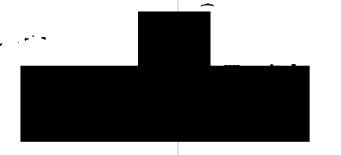
000182

....

MEDICAL RECORDS COPY

PAGE: END OF REPORT

FORM #:



PATIENT : MRN VISIT # : PMH MRN : SEX ADM MD ADM DATE: PT LOC ROOM



FINAL

REFERRING PHYSICIAN:

EXAM: ABDOMEN AP ABDOMEN AP

TIME: DATE: 01/18/99 0540 1817 01/17/99

ACCESSION #

REPORT

DATE OF SERVICE: 01/17/99, 01/18/99.

PROCEDURE PERFORMED: AP abdomen.

CLINICAL HISTORY: This is a 29-year-old man in whom we are asked to evaluate feeding tube placement and to rule out obstruction.

FINDINGS:

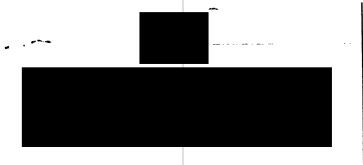
AP supine portable views of the upper abdomen were obtained on 01/17/99 at approximately 1806 and on 01/18/99 at 0539. There is gas and a little fecal material in the colon. No distended bowel loops are seen. A feeding tube is seen with the tip in the expected location of the proximal duodenum. The tube appears to have advanced very slightly on the second film as compared with the first. In addition to the feeding tube I see another fine line which I think is a ventriculoperitoneal shunt. This appears to overlie the midline of the lower dorsal spine and then loop into the left upper quadrant with the tip just below the left 12th rib. The pelvis is not included on either film.

000183

MEDICAL RECORDS COPY

PAGE : 1 CONTINUED





PATIENT : MRN ----: VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

ABDOMEN AP

ABDOMEN AP

DATE: 01/18/99 TIME: 0540

1817

ACCESSION #

The state of the s

IMPRESSION

01/17/99

CONCLUSION:

1. Fecal material and air can be seen in the colon - I do not see any evidence to suggest obstruction.

2. Feeding tube with tip in the duodenum.

3. There is believed to be a ventriculoperitoneal shunt line with tip in the left upper abdomen.

Dictated by:

M.D.

D: 01/18/99; 1558

Job

SIGNED BY: RESIDENT ID: M.D.

T: 19JAN1999

S: 19JAN1999-

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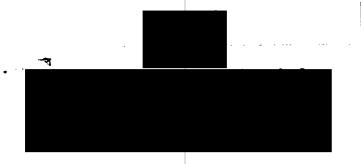
000184

MEDICAL RECORDS COPY

PAGE: 2

END OF REPORT

FORM #:



PATIENT : MRN ... : VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

REFERRING PHYSICIAN:

EXAM:

SONO, EXTREM VEIN UNIL DUP

DATE: 01/18/99 TIME: 1131

A CONTROL OF THE PARTY OF THE P

ACCESSION #

REPORT

DATE OF SERVICE:

01/18/99.

PROCEDURE PERFORMED:

Venous doppler sonogram.

CLINICAL HISTORY:

The patient is being evaluation for deep venous thrombosis at long term best rest for neurosurgical indication.

DISCUSSION:

Bilateral doppler compression ultrasound was performed from the common femoral through the popliteal regions bilaterally. Normal incremental compression, respiratory variation and augmentation was seen.

000185

MEDICAL RECORDS COPY

PAGE: CONTINUED

PATIENT : MRN : VISIT # : PMH MRN: DOB SEX ADM MD : ADM DATE: PT LOC : ROOM

FINAL

EXAM:

SONO, EXTREM VEIN UNIL DUP

DATE: 01/18/99

TIME: 1131

ACCESSION #

IMPRESSION

IMPRESSION:

No evidence for deep venous thrombosis for the level of the common femoral through the popliteal regions bilaterally.

Dictated by:

M.D.

D: 01/18/99; 1217

Job

SIGNED BY:

M.D.

RESIDENT ID:

T: 18JAN1999

S: 19JAN1999

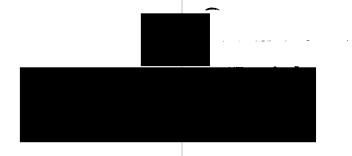
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000186

MEDICAL RECORDS COPY

....PAGE: 2 END OF REPORT

FORM #:



PATIENT : MRN - -VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

REFERRING	PHYSICIAN:
-----------	------------

EXAM: PORTABLE CHEST X-RAY DATE: 01/19/99 TIME: 0459

ACCESSION #

REPORT

DATE OF SERVICE: 01/19/99; 0459

PROCEDURE PERFORMED: Portable chest.

CLINICAL HISTORY:

Pneumonia.

FINDINGS:

A portable AP upright film of the chest done at 0444 on 01/19/99 shows no abnormality of the heart or lungs or change compared with films made one day earlier.

IMPRESSION

IMPRESSION:

Persistently normal portable chest.

Dictated by:

M.D.

<u>01/19/99</u>; 0906

Job

SIGNED BY: RESIDENT ID: M.D.

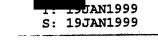
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MEDICAL RECORDS COPY

PAGE : END OF REPORT

FORM #:



PATIENT : MRN : VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

REFERRING PHYSICIAN:

EXAM:

PORTABLE KUB

DATE: 01/19/99 TIME: 0500

ACCESSION #

REPORT

DATE OF SERVICE: 01/19/99; 0500

PROCEDURE PERFORMED:

Portable KUB.

CLINICAL HISTORY:

Rule out obstruction.

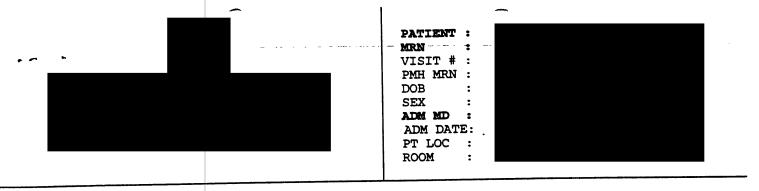
FINDINGS:

A portable kub done at 0444 on 01/19/99 shows that a Dobbhoff tube extends into the second portion of the duodenum. The abdominal gas pattern is unremarkable, and no abdominal organomegaly or bony abnormality is seen.

000188

MEDICAL RECORDS COPY

PAGE: CONTINUED



FINAL

EXAM:

PORTABLE KUB

DATE: 01/19/99 TIME: 0500

ACCESSION #

IMPRESSION

IMPRESSION:

1. Dobbhoff tube extends into the second portion of the duodenum.

2. Otherwise normal portable KUB with no change compared with film made one day earlier.

Dictated by:

D: 01/19/99; 0906

Job

SIGNED BY:

RESIDENT ID:

T: 19JAN1999

S: 19JAN1999

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000189

PAGE: 2

END OF REPORT

FORM #:

ADM DXS CODE:

MEDICAL RECORDS COPY

PATIENT : VISIT # : PMH MRN: ADM DATE:

FINAL

REFERRING PHYSICIAN:

EXAM:

SONOGRAM ABDOMEN

TIME: DATE:

01/19/99 1117

MRN

DOB SEX ADM MD

PT LOC ROOM

ACCESSION #

REPORT

DATE OF SERVICE: 01/19/99.

PROCEDURE PERFORMED: Abdominal sonogram.

CLINICAL HISTORY: Pancreatitis.

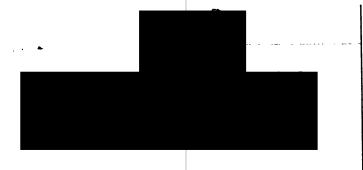
DISCUSSION:

Transverse and longitudinal images of the upper abdomen were obtained. The liver was homogeneous. The gallbladder was distended and tumefactive sludge was suspected as mass-like medium level echos were seen within the gallbladder lumen. A lobular contour was identified and the area did not move with positioning changes. No discrete stone was able to be identified within the presumed tumefactive sludge. The biliary tree was nondilated and the common bile duct was normal at 0.4 cm. The pancreas showed no gross abnormalities. The spleen measured 9.6 \times 9.7 \times 9.6 cm. The right kidney measured 11.8 \times 6.4 \times 4.9 cm and the left 10.3 \times 5.2 \times 4.5 cm. No hydronephrosis, perinephric fluid or focal mass was seen.

000190

MEDICAL RECORDS COPY

PAGE: 1 CONTINUED



PATIENT : MRN : VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

SONOGRAM ABDOMEN

DATE: 01/19/99

TIME: 1117

ACCESSION #

IMPRESSION

IMPRESSION:

- 1. Presumed tumefactive sludge within the gallbladder lumen with no discrete stone identified.
- No biliary ducal dilatation.
 No obvious pancreatic abnormality.

Dictated by:

M.D.

D: <u>01/19/99</u>; 1307

Job

SIGNED BY:

M.D.

RESIDENT ID:

T: 19JAN1999 S: 21JAN1999

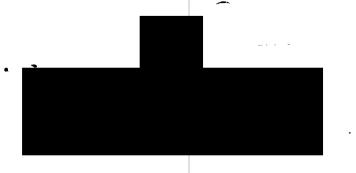
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MEDICAL RECORDS COPY

PAGE : 2 END OF REPORT

FORM #:



PATIENT : MRN - : VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC : ROOM

FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: TIME:

01/20/99 0225 ACCESSION #

REPORT

DATE OF SERVICE: 01/20/99; 0225.

PROCEDURE PERFORMED:

CT head.

REFERRING PHYSICIAN:

CLINICAL HISTORY:

This is a 29-year-old male patient status post removal of much of the right hemisphere for treatment of stroke.

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

As seen previously, much of the right hemisphere has been removed. The right thalamus and parts of the right frontal lobe have been preserved. A drain tube has been placed within a fluid collection occupying the right hemisphere. Denser components of the fluid are seen layering out posteriorly. There is no appreciable change in the degree of mass effect on the right lateral ventricle. There is minimal midline shift towards the left, which is unchanged since the prior study. The size of the left lateral ventricle is also unchanged.

000192

MEDICAL RECORDS COPY

PAGE: CONTINUED

PATIENT :
MRN :
VISIT # :
PMH MRN :
DOB :

SEX :
ADM MD :
ADM DATE:
PT LOC :

ROOM



FINAL

EXAM:

CT HEAD WO/CONT

- **DATE:** 01/20/99

TIME: 0225

ACCESSION #

IMPRESSION

IMPRESSION:

No significant change since 01/16.

Dictated by:

M.D.

D: <u>01/20/99;</u> 0913

Job

£

SIGNED BY:

RESIDENT ID:

M.D.

T: 20JAN1999 S: 21JAN1999

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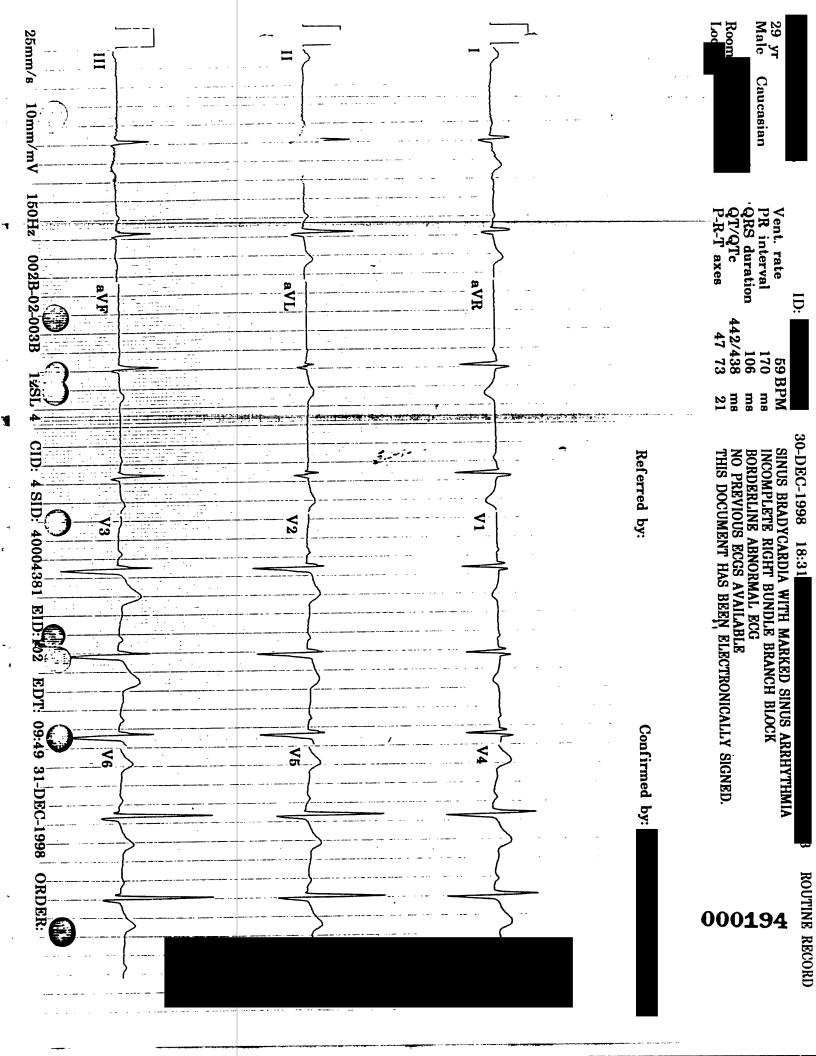
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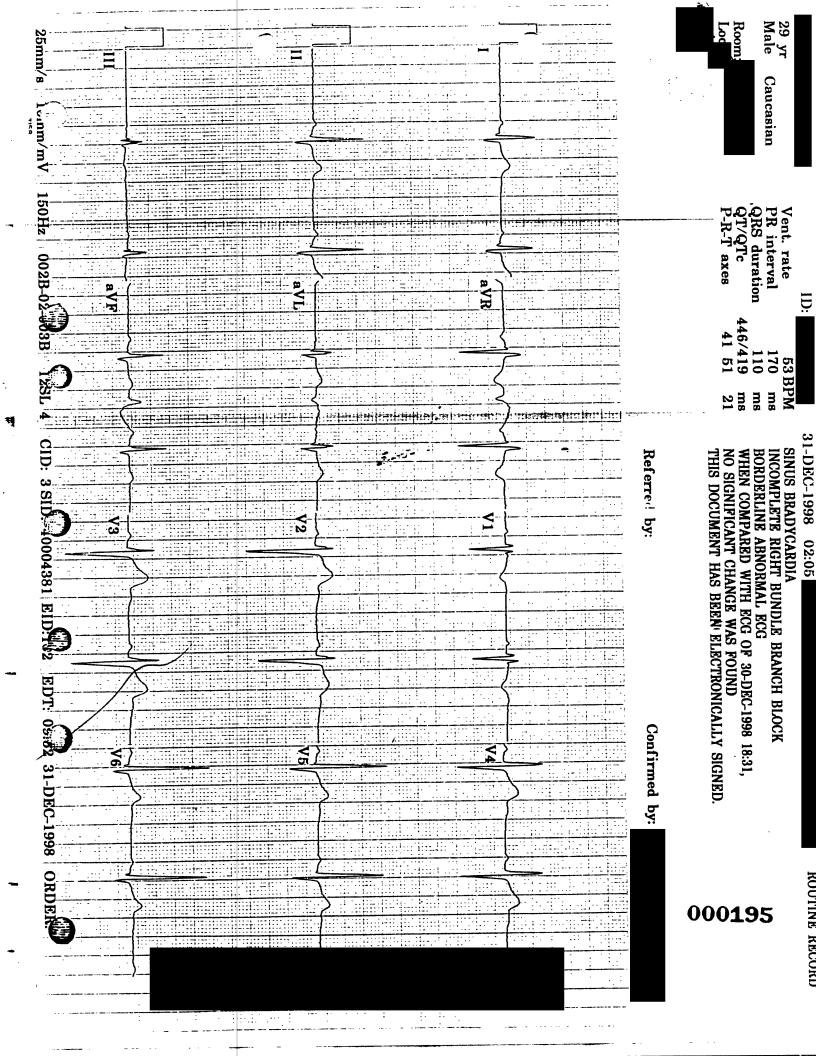
000193

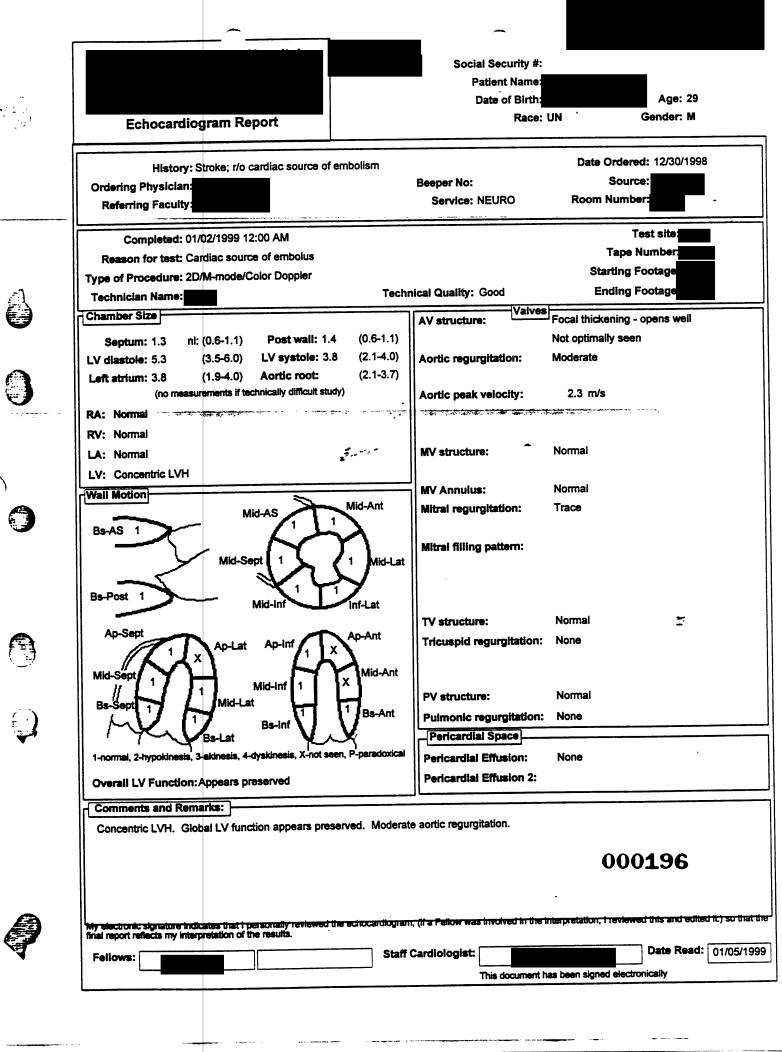
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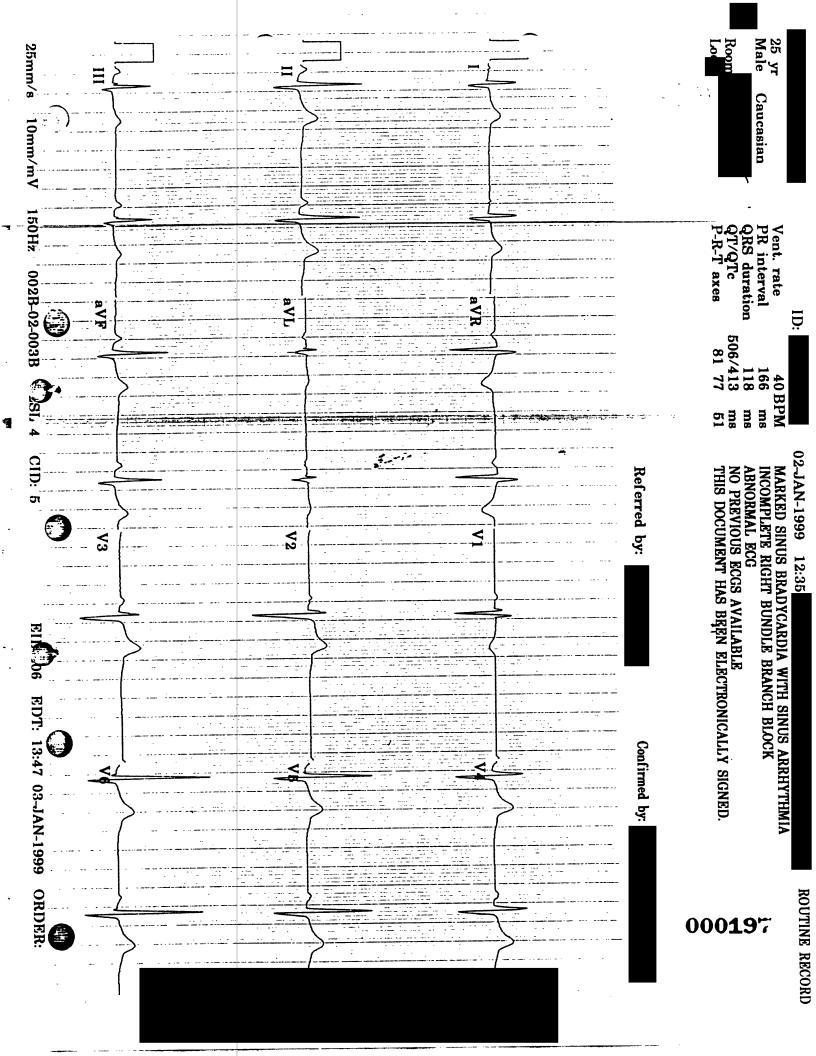
PAGE: 2 END OF REPORT

FORM #:









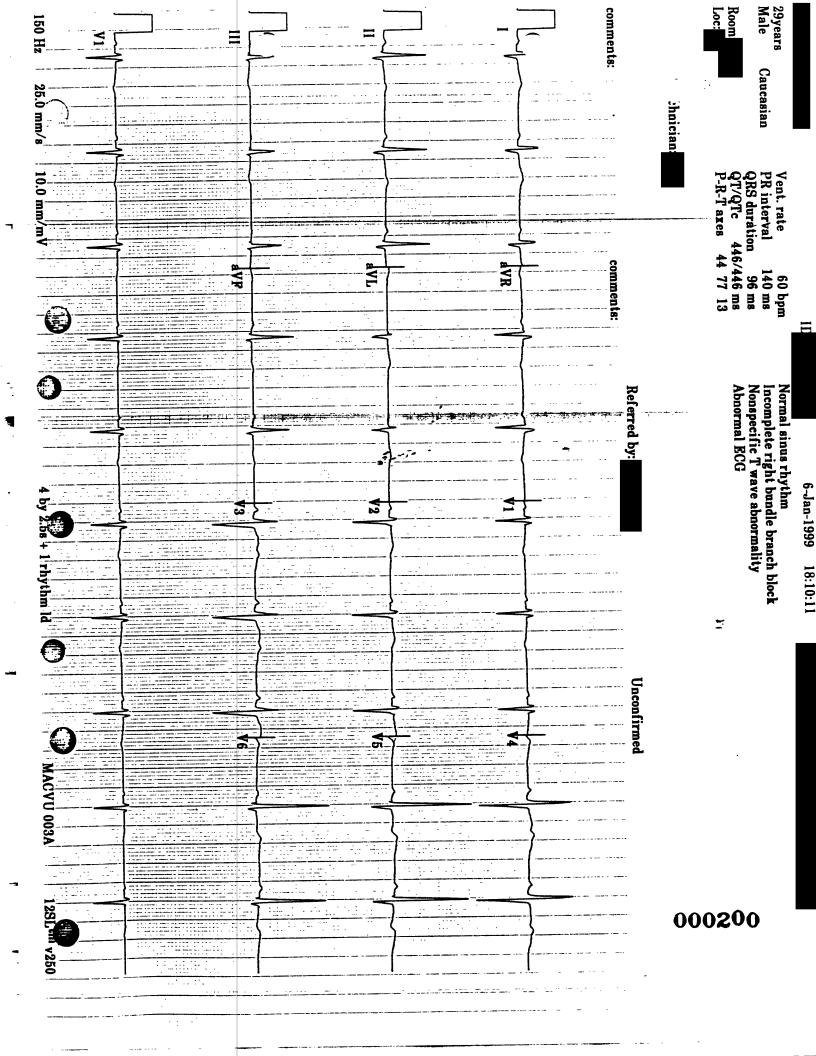
Transesophagea	Echocardiogram R	eport	Date of Birt Rac	h: Age: 29
Histo Ordering Physicia Referring Facu		of Embolism	Beeper No: Service: ICU	Date Ordered: 01/04/19 Source Room Number
Reason for test	: 01/04/1999 02:10 PM :: Cardiac source of em :: Transesophageal Ech	bolus ocardiogram	chnical Quality: Excellent	Test site Tape Number Starting Footage Ending Footage
Patient Data Monit			Valves	
BP:	baseline 153 / 64	post-TEE 153 / 63	AV structure:	Focal thickening - opens well Small mobile attachment(s)
HR: 02:	65	65 99	Aortic regurgitation:	Moderate
Rhythm: Meds given:	NSR Versed Morphine	NSR 8 mg 6 mg	MV structure: MV Annulus: Mitral regurgitation:	Normal None
LV Function	Inf-Post Ap-S	ept Ap-Inf	TV structure:	Normal
Mid-Sept 1	1 Inf-Lat	(\diamondsuit)	Tricuspid regurgitatio RV systolic pressure: PV structure: PV regurgitation:	
11	Mid-Lat Ap Mid-Ant sis, 3-skinesis, 4-dyskinesis	-Ant Ap-La	Pulmonary Artery: Ascending Aorta:	Normal Normal
Overall LV Funct	ion: Normal		Aortic Arch: Descending Aorta: Left Atrium:	Normal Mildly dilated
		,	Intracardiac shunts:	No thrombus seen No shunts detected Bubble study performed
Comments and	Remarks:			
I A size et upper	limite of normal No I A	or LA appendage thro hment is seen in the k	mbus seen. Normal LV systong-axis view. Moderate aort	olic function. Focally-thickened actic regurgitation. 000198
My electronic signature	e indicates that I was prese	nt during the entire proces	iure, I personally reviewed the ech	nocardiogram, (if a Fellow was involved
interpretation I reviews	ed and edited their findings)	so mar me is an isotor rea	lects my interpretation of the resul	Date Rea

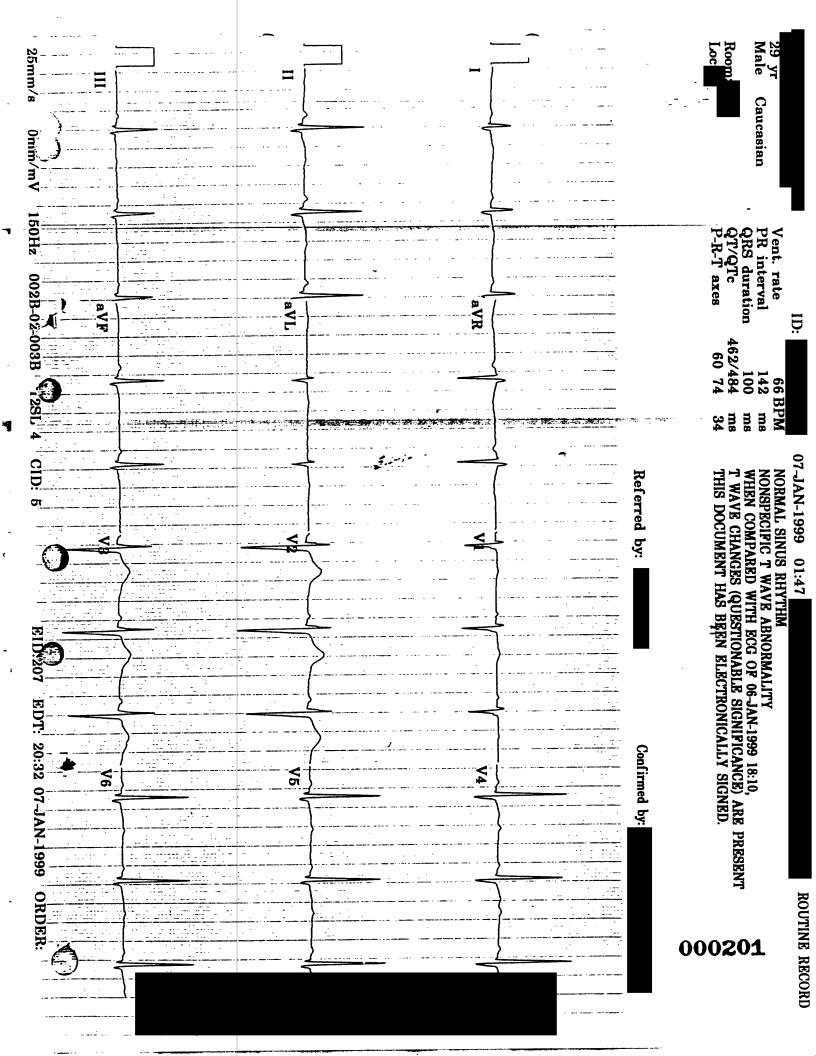
ELECTROENCEPHALOGRAPH. REPORT

	PATIENT N	
		SSN:
EEG Date:	1/5/1999	Test Location:
EEG#:		Electrode Type: Gold
	16:00	How Applied: Paste
Duration:	25 minutes	Electrode System: Modified Combinatorial
ICD-9: 345.9	CPT: 95819 E	Physiol. monitor: ECG
Handedness:	Right	States recorded: Comatose
Age: 29	Sex: male	Last Meal: IV
Birthdate:		Last Seizure: None
		Activation: Auditory/sensory stimulation
EEG Storage: Micr	rotilm	Medications: Cerebyx, Dilantin
EEG Fellow:		
Technologist		1111 of the andersohed take. He has had a cicht
TECHNOLOGISTS COM	MENTS: The patient was come	atose, with occasional biting of the endotracheal tube. He has had a right
frontal craniotomy.	he natient was admitted after coll	lansing while running on a treadmill. There was acute onset of headache, left
heminaresis, and sturred	speech. EEG evaluation was reg	prested to rule out subclimical status epilepulcus.
	V. This is an 19 channel anatho	EEG with ECG monitoring performed in the comatose state. igital EEG was referentially recorded, reformatted and digitally filtered in a
Hyperventilation and pho variety of bipolar and ref	tic stimulation were not done. Di erential montages for optimal dis	play.
background consisted of	8-10 Hz, up to 30 uV, non-rhythi ght hemisphere the background a Tactile stimulation resulted in it	d as comatose, no posterior dominant background rhythm was seen. The mic activity, intermixed with 2-3 Hz polymorphic slowing, over the left ctivity was suppressed, with up to 20 uV, 2-4 Hz, polymorphic slowing. No acreased delta slowing over the left hemisphere. No epileptiform discharges
HYPERVENTILATION	CHANGES: Hyperventilation v	vas not performed.
PHOTIC STIMULATIO	N CHANGES: Photic stimulation	n was not performed.
	<i>IMPRESS</i>	ION: Abnormal - Coma
	I Day homound I	_
Asymmetry-Dec	reasea Backgrouna L	ateralized Right Hemisphere
	lymorphic Delta Slowi	ing-Reactive: Generalized-Maximum Left
Hemisphere		
Continuous Th	eta Slowing-Reactive:	Generalized-Maximum Left Hemisphere
CLINICAL CO	RRELATION: This	EEG is severely abnormal. The lower voltages
over the right h	emisphere are consis	tent with a structural lesion on that side. The
reactive delta a	nd theta slowing is c	onsistent with a severe encephalopatny, though
the reactivity is	a good sign in an ot	herwise severely abnormal EEG.
i certify that	t I am the electroencephalog	rapher who personally reviewed this electroencephalogram.
		Physician Copies to:
		11.0

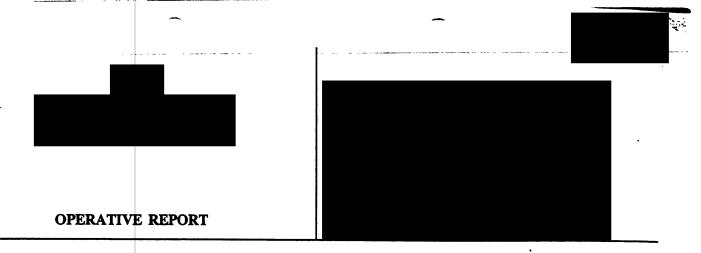
D

000199





FOURTH HOSPITALIZATION



DATE OF OPERATION:

03/10/99

PREOPERATIVE DIAGNOSIS:

Over shunted hydrocephalus.

POSTOPERATIVE DIAGNOSIS:

Over shunted hydrocephalus.

PROCEDURE:

Removal of medium pressure valve and placement of Medos programmable valve and Rickham reservoir right parietal region.

STAFF SURGEON:

M.D.

ANESTHESIA:

General, Dr.

ESTIMATED BLOOD LOSS:

Less than 50 cc.

FLUID:

800 cc.

VALVE PRESSURE SETTING:

140 mm of water.

COMPLICATIONS:

None.

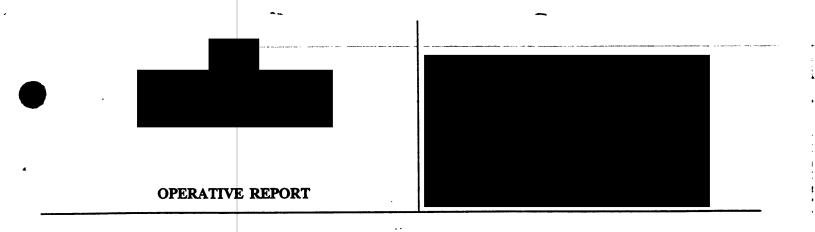
SPECIMENS:

None.

INDICATIONS FOR OPERATION: The patient is a gentleman who presented two months ago with stroke ultimately requiring a hemispherectomy for control of intracranial pressure. The patient has made a good recovery with movement of legs, right arm and excellent cognition and speech. He was shunted to his cavity during his initial admission. He now is developing incapacitating headaches when sitting up. The decision was made to remove his medium pressure valve and place a programmable valve. The hope was that although siphoning would occur, that the opening pressure could be controlled such that the headaches would be controlled. Consent was obtained from the patient's family. The risks and benefits of the procedure were thoroughly discussed.

OPERATIVE PROCEDURE:

The patient was identified, brought to the operating room and placed on the operating room table in the supine position where a member of the anesthesia department administered general endotracheal anesthesia and inserted all appropriate monitoring lines. The patient's head was then turned to the left on a horseshoe headholder. The right parieto-occipital region was shaved, prepped and draped in the usual sterile fashion. The previous valve incision was opened and extended down into the neck. Hemostasis was achieved with fishhooks. A self-retaining retractor was placed. The previous shunt was disassembled and a previously assembled Hakim-Codman programmable valve with a Rickham reservoir attached to it was attached to the distal tubing and secured with 2-0 silk suture. The previous medium pressure valve was then removed from the ventricular catheter and the programmable valve with the Rickham reservoir was attached and secured with



2-0 silk. The shunt pumped and refilled well. The entire wound was now copiously irrigated with saline. The galea was closed with interrupted inverted 2-0 Vicryl suture and the skin was closed with skin staples. Sterile dressings were applied. The patient was returned to the recovery room in stable condition and extubated.

D: 03/10/99 1210 T: 03/10/99 12:43

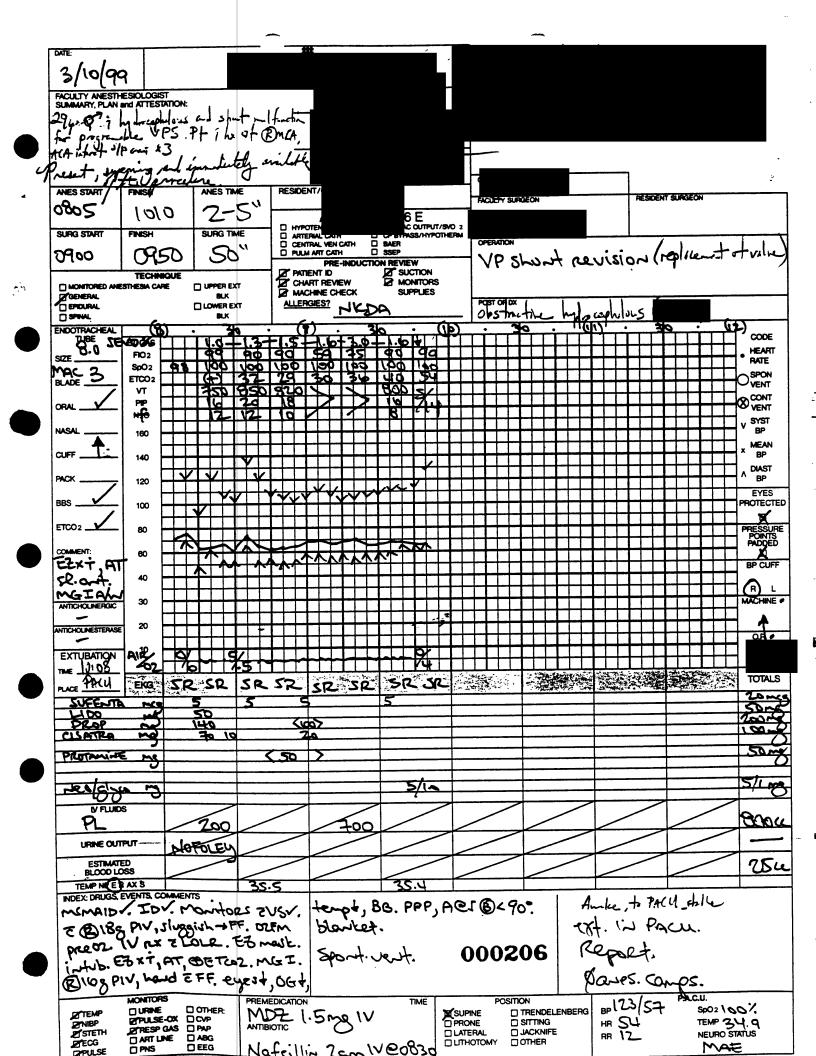
Job No:

cc:

000204

Page 2 of 2 CHART COPY

MONTH 2		
2-7 PRE & POST AN	ESTHESIA SUMMARY	
99 pre-up uptited	<u> 48/99</u>	
Hydrepholis;	VI shut melfuetion	14.3 226 PT (4.4)
PROPOSED OPERATION Programable VP	shut (L) AGE 29	(40 101) 4.0 35) ALT 94
HEENT/AIRWAY Pleeth EK Clan E grike I Muse pa de re	3 80 EV) 5'10"	AST 31
PULMONARY	assuration purposed	& Bur, Hypord diserce
a thouse	Pagar for RIOPE - The	eyotie Physicagalolas afete - who may agotie brust plan achance of scort brust BRUG THERAPY Burkst Longdon
& HTTV (Holding Mus	handlokan pladente	Bennet Stone Bragan Hyrani Phonegan Restoril Delowaring Sel-dipine
GKT- 12/48 MJR - S	s. [R130B]	Crancoto 33:2/98, 1/99 NotAC & made in made in the mad
y heralds & f	iansfrom 2 mos of?	ASA 1 2 3 4 5 E
NEUROLOGICAL 711 Mugania	s. The sate of the frat	I have discussed anesthesia with this Patient ☐ Spouse ☐ Family ☐ Parent ☐
Charte HA A - 2 T sho	1/2/14 to reholisement The lother vetice is L the green parged ins	TOR MIT 000205
SUMMARY AND ANESTHETIC PLAN 29-10 1000 1000 1000 1000 1000 1000 1000	ACA; MCA ordinar /m., Aprech injurious; H Huselons > ctro) monitors. Discussed	i justion writed _
POST-OPERATIVE NOTE POST-OPERATIVE NOTE	Dette 3/10/99 Time _	1015 No re-all Al Alex NAAC
NBS Stir	W.	Al strong -



grand Barrier and Artis			अ ुत्रे की भी भी भी गुड़ी	7,9,5,5°5,5°1.	4. 1914 - E		
Dete: 3-/0.	99	OR #		DElective	☐ Emerge	ency 4	
	DA						
		Oriented x 3	☐ Disoriented	☐ Drowsy	☐ Sedate	ed Unresponsive	ANSWERS APAROMATEL
LOC: Alert	& Awake						HPPROPERTURY
Skin Condition:	☐ Intact	□ Warm/Dry	☐ Cool/Moist	Cyanotic	□ Ked/E	excoriated	
Musculo/Skeletal:	☐ Pull ROM	Limited ROM	☐ Prosthesis	Other			
Cardio/Pulmonary:	Unremarka	ible SOB	☐ Trach/ETT	□0,			
Drains/Packs:	SZÓNIA	☐ Foley	□NGT	Chest Tube	Туре	Site	Drainage
Lines:	CV/Swan	☐ Arterial	Peripheral IV	☐ Type	(RT)	sextuale	
Psychosocial:	反 Caim	☐ Anxious ☐	Apprehensive				
Communication:	☐ No appares	nt limitation 🔲 Language	e barrier	aring impaired	☐ Visually	impaired	
Arrival from: DS	Pre-op Hol	ding ICU	Via:	□ Bed V2	Stretcher	Ø\$ide Rails ↑ X 2	
Time: Room In 2	805 Surgery	Start 0900 Surger	y End 0940	Room Out _		_	
Surgeous/Residents		$n \triangle$					
<u> </u>							
Assistants/Other:		,					
Anesthesia: Dr.		MD			CRNA	General □ Epidural	□ Local
Amestmesm: Dr		MD			CRNA	☐ Spinal Block Type:	
Dr.					CRNA	☐ IV Sedation	
Pre-Op Dx:	Hyses	cephalus					
Post-op Dx:	SAM	ع		€ در ر			
	A		Value				
Operative Procedure/s	E	vision of	VOIVE				
			•				
			2-4 - Loui :00	Scrub Person/s			1m/80 + Out /085
<u>Circulator/s</u>			385 Out 100	Scrub Person	2_		=// <i>y</i> //3 ==/003
							
Specimens: None				<u> </u>			
Specimens: None Routine							
Frozen							
-		•	<u> </u>				
Culture							
Other							207
	,						~~~
Implants:	Yes: See In	nplant Record					

Please Do Not Separate
Page 1 of 3
8/97 Operating Room Record

CONSULTATION-FIBEROPTIC UPPER GASTROINTESTINAL ENDOSCOPY

	·	
DATE: 3 15/51 AGE	SEX_P REFERRING PHYSICIAN	
Indications: 5 r V	Shunt LUQ pain. About CTO	•
Informed consent Abnormal Diagnostic Data ad Risks/Benefits/Alternatives dia Anesthetic History and Agents Plan for anesthesia:	scussed: yes no Blood prod discussed: yes no ASA Class	nysical yes no duct consent yes no sification
TECH. DATA: BIOPSY: □	□ yes □ no Cytology: □ yes □ no Pic	tures: 👿 yes 🗆 no
□ POLYPECTOMY	☐ FOREIGN BODY REMOVAL ☐ OTHER ADDITION	ONAL PROCEDURE
ENDOSCOPE: GIC	Benach SO FLUORO. TIME:	
MEDICATION: Dime P	75 Non 5 STAFF:	
FINDINGS: ESOPHAGUS:	Y 0	
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ASSESSMENT: I was present impression(s) and assessment		loscope. These are my
NL ECP - NL MUC		
STAFF SIGNATURE		
PROCEDURE SUPER	ENDOSCOPIS	

dications:	. 25		e .		
dications:	CONSULTATION-FIBERO COLONOSCOPY	PTIC SIGMOIDOSCOPY, AND ILEOSCOPY	·		
formed consent onormal Diagnostic Data addressed: yes no	A12.	29 SEX M R	EFERRING PHYSIC	IAN	
ECH. DATA: BIOPSY: yes no	nformed consent bnormal Diagnostic Data add tisks/Benefits/Alternatives dis	ressed: yes not	o o , o	Blood prod	uct consent
NDOSCOPE: C100 POLYPECTOMY: yes 2 no MEDIGATION: Description of examined normal PRE Novual. PRENdo not examined normal PRENdo not examined normal Novual T- Jeum ASCENDING COLON not examined normal Novual T- Jeum O00209 TERMINAL ILEUM not examined normal TERMINAL ILEUM not examined normal ASSESSMENT: was present for procedure insertion, visualization.	ECH. DATA: BIOPSY:	yes 💢 no CYTOLO	OGY <i>₹</i> yes	y⊠ no Pi	ctures: 🗷 yes 🗆 n
STAFF: INDINGS: RECTOSIGMOID not examined normal PRE No vuol. DESCENDING COLON not examined normal TRANSVERSE COLON not examined normal No vuol Volonosuo No vuol Volon		POLYP	ECTOMY:	<u></u>	
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ASSESSMENT: I was present for procedure insertion, visualization,	CECUM	not examined Apermal			000209
ASSESSMENT: I was present for procedure insertion, visualization,					
ASSESSMENT: I was present for procedure insertion, visualization,	TEDMINAL II FI IM	not examined normal			
assessment(s).	ASSESSMENT: I was present for and withdrawal of the endoscope.	procedure insertion, visualization,	al Colonosi	·P7	

ENDO

ID#

White-Medical Record

STAFF SIGNAT





OPERATIVE REPORT

DATE OF OPERATION:

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS:

PROCEDURE:

SURGEON:

ASSISTANT:

ANESTHESIA:

ANESTHESIOLOGIST:

COMPLICATIONS:

ESTIMATED BLOOD LOSS:

DRAINS:

DISPOSITION:

03/23/99

Infected ventriculoperitoneal shunt.

Infected ventriculoperitoneal shunt.

Removal of right parietal occipital ventriculoperitoneal shunt.

M.D.

M.D.

General endotracheal.

M.D.

None.

10 cc.

None.

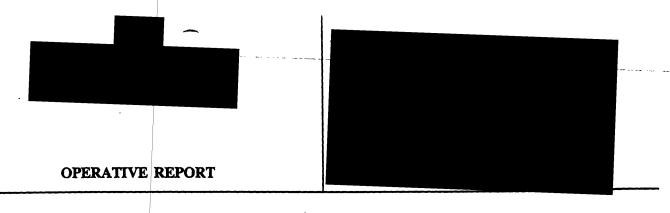
To post anesthesia care unit in stable condition.

STATEMENT OF MEDICAL NECESSITY: The patient is a 29-year-old male who had a right parieto-occipital ventriculoperitoneal shunt placed. This was converted to a programmable valve approximately two weeks ago. The patient then developed abdominal discomfort. CT scan eventually showed a fluid collection in the abdomen. This was tapped as well as the shunt reservoir. The fluid grew organisms consistent with infection. Therefore decision was made to remove the shunt which entered in the right parietal occipital area into the right hemisphere cavity where the patient had previously undergone

hemispherectomy.

DESCRIPTION OF OPERATION: The patient was taken to the operating room where general endotracheal anesthesia was induced. He was then placed in the supine position with all pressure points padded. The head was placed in a horse shoe head holder and turned gently to the left. The previous right parietal occipital wound still has the staples in. The surrounding area was shaved, prepped and draped in the usual sterile fashion. The staples in the middle portion of the wound were removed with hemostat and the wound was opened with a self retaining Gelpi retractor. The Rickham reservoir and the proximal shunt tubing as well as the valve and additional shunt tubing were identified. The 4-0 Nurulon sutures that were holding the mechanism in place were cut and the intracranial portion, the Rickham reservoir, the valve and the distal tubing were removed im entirety. There was clear fluid coming from the bur hole under low pressure.

000210



The wound was then thoroughly irrigated with saline and then the portion of the wound that was reopened was closed with an interrupted 3-0 nylon in a vertical mattress type suture. Sterile dressing was applied and the patient was then awakened and take to the post anesthesia care unit in stable condition.

M.D.(faxed)

By: , M.D.

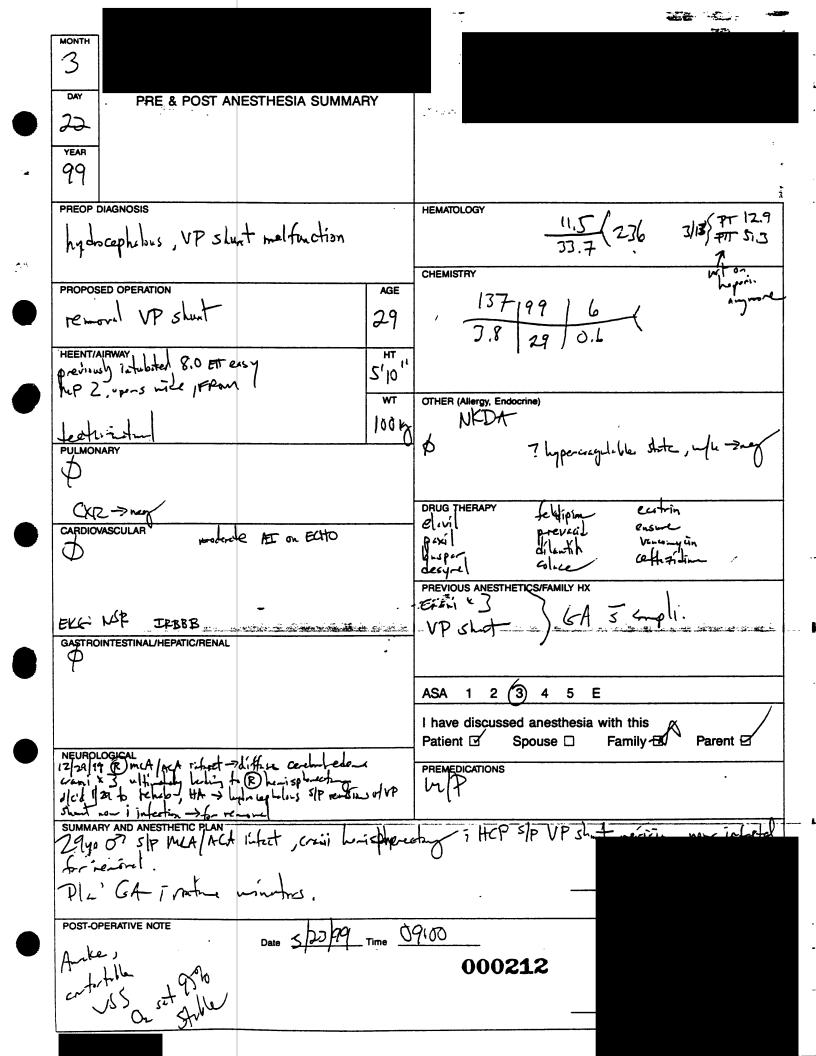
D: 03/23/99 0832 T: 03/23/99; 0955

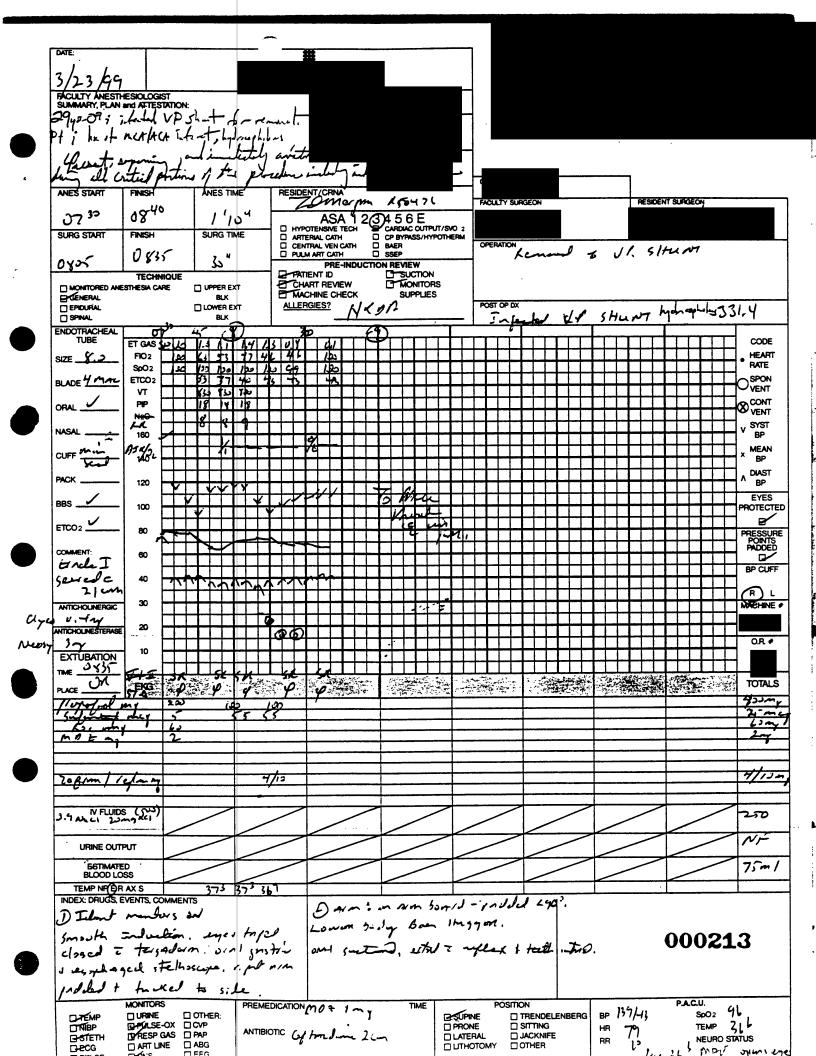
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000211

Page 2 of 2 CHART COPY





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	'DA	. 087							
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neculo/Skeletal:	□ Full ROM	ZaLimited ROM	☐ Prosthesis	Other		<u></u>			
rdio/Pulmonary:	Unremarkal		☐ Trach/ETT	□ O ₂					
nins/Packs:	Ø∕N/A	☐ Foley	□NGT	☐ Chest Tube	Туре	Site	_ Drainage		,
net:	□ CV/Swan	☐ Arterial	Peripheral IV	☐ Type		Site	ar hi	9100	
rchosocial:	☑ Calm	☐ Anxious [Apprehensive	,	· · · · · · · · · · · · · · · · · · ·				
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Please Do Not Separate Page 1 of 3

PATTENT:
MRN:
VISIT #:
PMH MRN:
DOB:
SEX:
ADM MD:
ADM DATE:
PT LOC:
ROOM:

FINAL

REFERRING PHYSICIAN:

EXAM:

SPECIAL PROCEDURE

DATE:

TIME: 1541

ACCESSION #

REPORT

03/25/99

CLINICAL HISTORY:

A 29-year-old man needing long-term IV access.

TECHNIQUE:

Informed consent was obtained from the patient's wife. The patient was placed in a supine position on the fluoroscopy table. The patient's left upper extremity was prepared in the usual sterile manner. Lidocaine was utilized for local anesthesia. Using ultrasound guidance through a micropuncture needle, said access to the left basilic vein was obtained. Using exchange technique, a PICC line was placed with its tip near the atriocaval junction.

The patient suffered no post procedure complications.

000215

MEDICAL RECORDS COPY

PAGE : :

PATIENT : MRN VISIT # PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM



FINAL

EXAM:

SPECIAL PROCEDURE

DATE: 03/25/99 TIME: 1541

The second secon

ACCURSION #

IMPRESSION

PICC line placement.

Dictated by:

M.D.

D: 03/25/99; 1644

Job

I personally reviewed the film(s) and the report above and concur.

SIGNED BY: RESIDENT ID:

26MAR1999 S: 30MAR1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

000216

MEDICAL RECORDS COPY

PAGE : 2 END OF REPORT

FORM #:

	Date: 3 25 99			
	ID Band On:	Pulses:		
	Pre-op Teaching:	PT - R L	•	
٠,	Permit Signed:	Other - R L	•	
	Labs: No Partie Y/N	Special Conditions		
	Creat	opeda oondiion		
* *1	PT-PTT		Chart and History Reviewed	•
.*."	Other			
	IV Access - Type: Hoylo	CK Darn Site:	1	
			Preg Status:	
	Invasive Lines - Y (R) Type:		NPO: 🗑 N	
	Hemodynamic Drips - Y			
	Procedure: <u>PICCLIU</u>	0	Approach: (4) ally	
	Procedure:			
	Pre-op Dx: Cani X3	Trench PICCA	on IVTX	
	Post-op Dx:	U		
		1-20		
	7 II gio II II	art: <u>/535</u>	Cath/Sheath Out:	
	Out: 1600 Er	0	ethopialogist (
	Radiologist:	Ane	sthesiologist:	
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	Scrub	•	Tech:	
	Tech:			N Cadadian
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THE CONTRACTOR OF THE

I	PROCEDURE	DATE TIME DAY	03/20/99 0125 SAT	03/18/99 0614 THU	03/16/99 1225 TUE	UNITS	REFERENCE RANG	GE
	BLOOD COUNT WBC X 10^3 RBC X 10^6 HGB	г	9.1 3.91 L 12.1 L	9.9 3.76 L 11.5 L	9.0 4.34 13.0L	/uL /uL g/dl	[4.1-10.9] [4.30-5.90] [13.2-16.2]	
i I I	HCT MCV MCH MCHC RDW 1SD		34.9L 89.1 30.8 34.6 11.2	33.7L 89.5 30.5 34.1	38.7L 89.2 30.0 33.6 11.8	% FL pG g/dl %	[40.0-52.0] [82.0-100.0] [26.5-34.0] [31.8-35.1] [< 14.5]	
1	PLATELET COM PLT X 10^3 MPV	UNT	299 6.5 L	236 6.5 L	199 6.6 L	/uL FL	[140-440] [6.7-10.2]	
•	DIFFERENTIAL TOTAL NEUT % TOTAL NEUT% M SEGS %	AN	81H	77H	87.3 H	8	[37.0-73.0] [37-73]	THE WANT SHOW YOU
	SEGS % BANDS % LYMPH % LYMPH % MANUA		22H 14L	9 12 L	5.8L	& & &	[0-10] [20.0-46.0] [20-46]	
1	MONO % MONO % MANUAL EOS %		4	10	5.3 1.5	육 용 용	[2.0-12.0] [2-12] [0.0-5.0]	
	EOS % MANUAL BASO % BASO % MANUAL TOTL NEUT X10		0	1 0′	0.1 7.9 H	% % % /uL	[0-5] [0.0-2.0] [0-2] [2.0-5.0]	·
	TOTL NEUT X10 TOTL NEUT X10 LYMPH # X10^3 LYMPH# MANx10)^3 }	7.4H 1.3	7.6H 1.2L	.5L	u/L /uL u/L	[2.0-5.0] [1.3-3.0] [1.3-3.0]	(L)
	MONO # X10^3- MONO # MANX10 EOS # X10^3 EOS # MAN X10)^3	0.4	1.0	0.1	u/L u/L /uL u/L	[0.1-1.0] [0.1-1.0] [0.0-0.3] [0.0-0.3]	<u>,</u>
	BASO # X10^3 Legend: L = Low, H =				0.0	/uL	[0.0-0.2]	218

CONTINUED ON NEXT PAGE: 1 LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS

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	DATE TIME DAY	03/20/99 0125 SAT	03/18/99 0614 THU	03/16/99 1225 TUE			
	PROCEDURE				UNITS	REFERENCE RANGE	
)	DIFFERENTIAL BASO # MANX10^3	0.0	0.0		u/L	[0.0-0.2]	
	MORPHOLOGY			•			
	RBC MORPHOLOGY	normal*	NORMAL*	•			
	DATE TIME DAY	03/15/99 0130 MON	03/05 7.99 2123 FRI	02/27/99 1230 SAT	•		
	PROCEDURE				UNITS	REFERENCE RANGE	
	BLOOD COUNT WBC X 10^3	9.6		4.8	/uL	[4.1-10.9]	
	RBC X 10^6	4.59 14.1		4.72 14.3	/uL G/DL	[4.30-5.90] [13.2-16.2]	
	HGB HCT	40.9		41.6	8	[40.0-52.0]	
	MCV	89.2		88.1	FL	[82.0-100.0]	
	MCH	30.8	and the second second		pG G/DL	[26.5-34.0]	-131
	MCHC RDW 1SD	34.6 12.2		34.3 12.2	8 G\DT	[< 14.5]	
	PLATELET COUNT	188	186	226	/uL	[140-440]	
	PLT X 10 ³	6.6L	186	6.0L	FL	[6.7-10.2]	
			/				
	DIFFERENTIAL			61.7	8	[37.0-73.0]	
	TOTAL NEUT % TOTAL NEUT% MAN	89H		61.7	₹ 8	[37-73]	
	SEGS &	75H			*	[37-73]	i.
	BANDS %		To a real property	water trade and trade to the days		• (0 - 10)	<u> </u>
	LYMPH %			26.4	8	[20.0-46.0]	
	LYMPH % MANUAL	8L		. 7 -	ક ક	[20-46] [2.0-12.0]	
	MONO % MONO % MANUAL	2		7.5	₹ %	[2-12]	
	TONO O TEMPORE				-		₹.,
	Legend:		ı			000219	
	L = Low, H = High,	= Abnormal		ED ON NEXT PAG	E PAG	E: 2	
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LABORATORY REPORT



HEMATOLOGY CALL

PROCEDURE	DATE TIME DAY	03/15/99 0130 MON	03/05/99 2123 FRI	02/27/99 1230 SAT	UNITS	REFERENCE RANGE
DIFFERENTIAL	L					
EOS %				3.0	*	[0.0-5.0]
EOS % MANUAL BASO %		1		1 4	₹	[0-5]
BASO % MANUAI		0		. 1.4	\$ \$ \$	[0.0-2.0] [0-2]
TOTL NEUT X10				2.9	/uL	[2.0-5.0]
TOTL NEUT X10	-	8.5H			_u/L	[2.0-5.0]
LYMPH # X10^3			والمراجع والمنطق	1.3	/uL	[1.3-3.0]
LYMPH# MANx1(MONO # X10^3)^3	0.8L		0.4	u/L	[1.3-3.0]
MONO # AIU 3)^3	0.2		0.4	/uL u/L	[0.1-1.0] [0.1-1.0]
EOS # X10^3	, ,	0.2		0.1	/uL	[0.0-0.3]
EOS # MAN X10)^3	0.1			u/L	[0.0-0.3]
BASO # X10^3				0.1	/uL	[0.0-0.2]
BASO # MANX10)^3	0.0			u/L	[0.0-0.2]
MORPHOLOGY	Y					·

RBC MORPHOLOGY MORMAL

000220

Legend:

L = Low, H = High, * = Abnormal

CONTINUED ON NEXT PAGE

PAGE: 3

LABORATORY REPORT



COAGULATION A

DATE TIME DAY 03/13/99 0520 SAT

03/12/99 1100 FRI

03/12/99 0708 FRI

PROCEDURE

UNITS

REFERENCE RANGE

ROUTINE COAGULATION

PROTIME

12.9H 12.4 12.9H

second [10.5-12.8]

A new Protime reagent is in use as of 12/03/98. It is more sensitive with an ISI of 1.02. Protime results in seconds may be longer, but there is no change in therapeutic INR (2.0 - 3.0).

INR

_ INR 1.1 THE INR (INTERNATIONAL NORMALIZED RATIO) IS INTENDED FOR PATIENTS ON STABLE LONG TERM ORAL ANTICOAGULANT

THERAPY. INR VALUES SHOULD APPROXIMATE 2.0 TO 3.0 IN MOST CASES, AND 2.5 TO 3.5 FOR HIGHER INTENSITY OF

ANTICOAGULATION. PTT

51.3H 47.4H 56.4H

second [22.0-35.0]

40 - 80THERAPEUTIC RANGE FOR UNFRACTIONATED HEPARIN: seconds

> DATE TIME

03/11/99 2300

03/11/99

03/11/99

DAY

THU

1840 THU

1125 THU

PROCEDURE

UNITS REFERENCE RANGE

ROUTINE COAGULATION

PROTIME INR PTT

12.1 1.0 48.4H 12.6 1.1 47.3H 12.8 1.1 49.5H second

[10.5-12.8]

INR

[22.0-35.0] second

000221

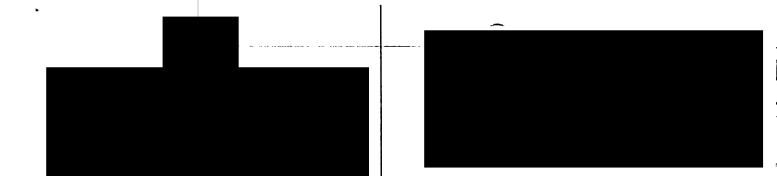
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Legend: H = High

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LABORATORY REPORT



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	PROCEDURE	DATE TIME DAY	03/11/99 0225 THU	03/10/99 1140 WED	03/10/99 0525 WED	UNITS	REFERENCE RANGE	
)	ROUTINE COAC PROTIME INR PTT PTT 03/11/9	>1	12.8 1.1 100 SECCf	12.8 1.1 26.3 ESULTS CALLE	12.6 1.1 .26.0	second INR second second .,03/11/99 0	[10.5-12.8] [22.0-35.0] [22 - 35] 3:12,	
	PROCEDURE	DATE TIME DAY	03/09/99 2340 TUE	03/097.99 1732 TUE	03/09/99 1255 TUE	UNITS	REFERENCE RANGE	
	PROTIME INR	DATE	12.4 1.1 55.1H	12.3 1.1 42.1 H	12.5 1.1 27.0	second INR second	[10.5-12.8] [22.0-35.0]	عين ٩
)	PROCEDURE	TIME DAY	TUE		MON	UNITS	REFERENCE RANGE	
	PROTINE COAD	GULATIC	13.3H 1.1 63.7H	13.0H 1.1 59.0H	12.8 1.1 60.0H	second INR second	[10.5-12.8]	

000222

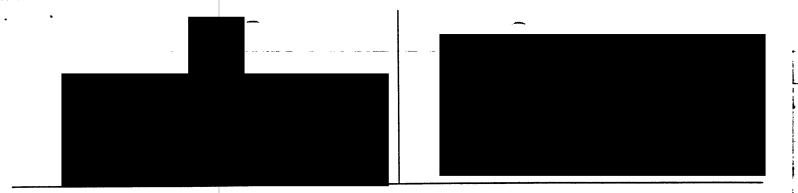
Legend:

H = High, C = Critical, f = Footnote

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PAGE: 5

LABORATORY REPORT



COAGULATIONES

	PROCEDURE	DATE TIME DAY _	03/08/99 1125 MON	03/08/99 0440 <u>MON</u>	03/07/99 2330 SUN	UNITS	REFERENCE RANGE	
	ROUTINE COAPROTIME INR PTT	GULATIO	N 13.1H 1.1 70.3H	13.3H 1.1 64.4H	13.0H 1.1 .64.9H	second INR second	[10.5-12.8] [22.0-35.0]	
	PROCEDURE	DATE TIME DAY _	03/07/99 1820 SUN	03/07/99 1210 SUN	03/07/99 0414 SUN	- UNITS	REFERENCE RANGE	
	ROUTINE COA PROTIME INR PTT	GULATIO	12.9H 1.1 61.3H	12.6 1.1 47.3 H	12.6 1.1 61.0 H	second INR second	[10.5-12.8] [22.0-35.0]	
	PROCEDURE	DATE TIME DAY	03/06/99 2300 SAT	03/06/99 1745 <u>SAT</u>	03/06/99 1140 SAT	UNITS -	reference_range=	
,	ROUTINE COA PROTIME INR PTT	GULATIO	12.7 1.1 56.5H	12.4 1.1 49.0 H	12.3 1.1 36.6 H	second INR second	[10.5-12.8] [22.0-35.0]	

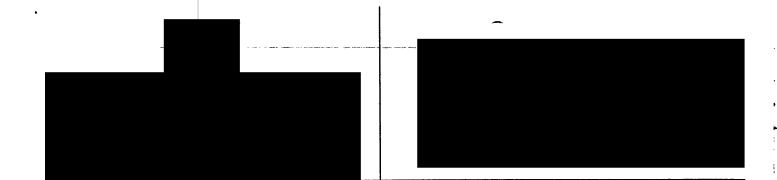
000223

Legend: H = High

CONTINUED ON NEXT PAGE

PAGE: 6

LABORATORY REPORT



COAGULATIONS

DATE TIME DAY

03/06/99 0430 SAT

03/06/99 0300 SAT

03/05/99 2123 FRI

PROCEDURE

UNITS REFERENCE RANGE

ROUTINE COAGULATION

THROMBIN TIME 03/05/99 2123 THROMBIN TIME FOOTNOTE*f

second [14.0-18.0]

REFERENCE RANGE:14-18 >60 SECONDS

RESULTS CALLED IN 12.8

1.1

RN 03/06/99 03:28 INR

second [10.5-12.8]

PROTIME INR PTT FIBRINOGEN D-DIMER

64.8H أرستوريج

148.0L <0.5

[22.0-35.0] second MG/DL [150.0-400.0]

[<0.5]

DATE TIME DAY

03/05/99 1855 FRI

12.6

60.1H

03/05/99 1219 FRI

03/05/99 0530 FRI

UNITS

REFERENCE RANGE

ROUTINE COAGULATION

PROTIME PROTIME INR PT 1:1

PTT

PROCEDURE

13.5H 13.5H

÷ 1÷2~-

13.3H

69.4H

1.1

second second

[10.5-12.8][10.5-12.8]

INR

second

[10.5-12.8][22.0-35.0] second

80.8H

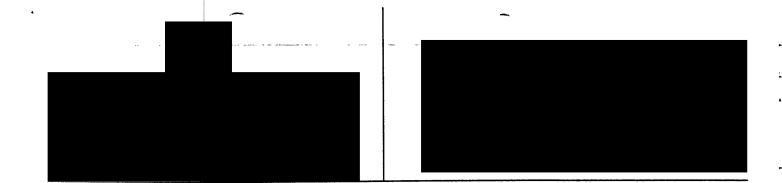
000224

Legend:

L = Low, H = High, * = Abnormal, f = Footnote

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PAGE: 7



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1	. A CONTRACTOR STATE AND A STATE OF THE STAT	~ 2000		James C. D. James	~	3-13-14-14-14-15-14-15-14-14-14-14-14-14-14-14-14-14-14-14-14-	DOCUMENTS OF STREET
	Salara Palai GO	-	99.00			AND DESCRIPTION OF THE PARTY OF	Appropriate South State of Street, St. Co.
	The state of the s	ns-				The same and the same of the same of the same	- Committee to the first of the ort
			4.7			STREET SHEET MANAGEMENT AND ADDRESS.	AND PERSONAL PROPERTY AND PROPE
	A CHARLES AND ADDRESS OF THE PARTY OF THE PA						the car of the state of the
	75 CONTROL OF THE PARTY OF THE	79 m	~~~,	CANONIC MENT	Sichalia.	ALMAN CANADAM WAS AS BELL	CAMMANDE A MAGANTANA

	PROCEDURE	DATE TIME DAY _	03/05/99 0500 FRI	03/04/99 1900 THU	03/04/99 1135 <u>THU</u>	UNITS	REFERENCE RANGE	
)	ROUTINE COAPROTIME INR PTT	GULATIO	13.4H 1.2	12.9H 1.1 56.1H	12.9H 1.1 ·35.3H	second INR second	[10.5-12.8] [22.0-35.0]	
	PROCEDURE	DATE TIME DAY	03/04/99 0518 THU	03/04/99 0430 	03/04/99 . 0020 THU	- UNITS	REFERENCE RANGE	
	ROUTINE COA PROTIME INR PTT	GULATIC	56.1H	13.4 H 1.2	13.0H 1.1 66.8H	second INR second	[10.5-12.8] [22.0-35.0]	
	PROCEDURE	DATE TIME DAY	03/03/99 2320 WED	03/03/99 1743 WED	03/03/99 1110 <u>WED</u>	UNITS	REFERENCE RANGE	nai an d
•	ROUTINE COA PROTIME INR PTT	GULATIO	12.4 1.1 38.3H	13.1H 1.1 55.3H	13.8H 1.2 53.0H	second INR second	[10.5-12.8] [22.0-35.0]	

000225

Legend: H = High

CONTINUED ON NEXT PAGE

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LABORATORY REPORT



COAGULATION COAGULATION

PROCEDURE	DATE TIME DAY	03/03/99 0430 WED	03/02/99 2300 TUE	03/02/99 1800 TUE	UNITS	REFERENCE RANGE
ROUTINE CO	AGULATI	ON				
PROTIME INR		13.5 H	13.2 H 1.1		second INR	[10.5-12.8]
PTT		45.7H	51.4H	. 51.9 H	second	[22.0-35.0]
	DATE TIME DAY	03/02/99 1700 TUE	03/02/99 1130 TUR	 03/02/99 . 0510 TUE	-	
PROCEDURE	DAI	105			UNITS	REFERENCE RANGE
ROUTINE CO	AGULATI	ON				
PROTIME		13.4H	14.1 H 1.2	13.9 H 1.2	second INR	[10.5-12.8]
INR PTT		1.1	51.4H	62.2H	second	[22.0-35.0]
	DATE TIME	03/01/99 2305	03/01/99 1726	03/01/99 1222		
	DAY	MON	MON	MON	TINTOS S	REFERENCE-RANGE
PROCEDURE					ONLID	TULL DILDERICA - TURICA
ROUTINE CO	AGULATI	ON			_	
PROTIME		14.2H 1.2	13.2H 1.1	14.4 H 1.2	second INR	[10.5-12.8]
INR PTT		47.8H	49.5H	52.5H	second	[22.0-35.0]

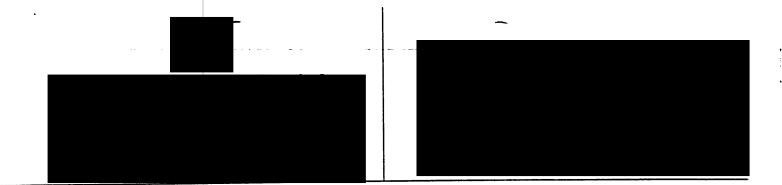
000226

Legend: H = High

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LABORATORY REPORT



COAGULATION ...

	PROCEDURE	DATE TIME DAY _	03/01/99 0420 MON	02/28/99 1915 	02/28/99 1105 SUN	UNITS	REFERENCE RANGE
_	ROUTINE COA	GULATIC		15.1 H	16.4 H	second	[10.5-12.8]
•	PROTIME		14.6H 1.3	1.3	1.4	INR	[2010 2210]
	INR PTT		51.7H	46.4H	.37.8H	second	[22.0-35.0]
		DATE	02/28/99	02/27/99	02/27/99		
		TIME	0515	1900	1230	_	
		DAY	SUN	SAT	SAT	_	
	PROCEDURE			-		UNITS	REFERENCE RANGE
	ROUTINE COA	GULATIC	Ň				
	PROTIME		16.6H	21.2H	24.2H	second	[10.5-12.8]
	INR		1.4	1.8	2.1	INR	
	PTT		46.3H		33.2	second	[22.0-35.0]
	PTT			>100 SECCf		second	[22 - 35]
				ESULTS CALLE		02/27/99	20:31;
		1	RESILTES RE	PEATED AND V	ERIFIED		

000227

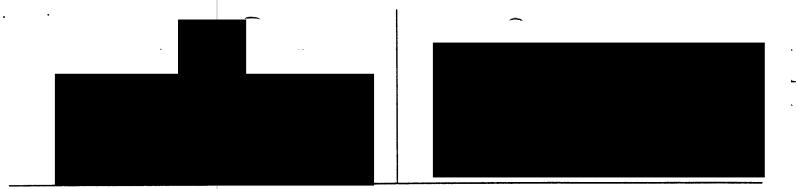
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H = High, C = Critical, f = Footnote

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LABORATORY REPORT



URINALYSIS

03/14/99 02/27/99 03/18/99 DATE 1200 2100 2215 TIME THU SUN DAY

UNITS REFERENCE RANGE **PROCEDURE**

MACROSCOPIC

YELLOW STRAW YELLOW COLOR [CLEAR] CLEAR CLEAR CLOUDY* APPEARANCE

CHEM STRIP

NEGATIVE NEGATIVE NEGATIVE [NEGATIVE] GLUCOSE NEGATIVE NEGATIVE NEGATIVE [NEGATIVE] BILIRUBIN [NEGATIVE] NEGATIVE NEGATIVE NEGATIVE KETONES [SG REF] 1.025 1.015 >=1.030* SPEC GRAVITY NEGATIVE [NEGATIVE] NEGATIVE NEGATIVE BLOOD [4.5-8.0]7.5 7.5 6.0 PH [NEGATIVE] TRACE* NEGATIVE NEGATIVE PROTEIN [0.2-1.0]0.2 UROBILINOGEN 0.2 0.2 NEGATIVE NEGATIVE [NEGATIVE] NITRATE NEGATIVE NEGATIVE [NEGATIVE] NEGATIVE NEGATIVE LEUKO ESTERASE NO MICRO NEEDED?

MICROSCOPIC ANALYSIS IS NOT INDICATED WHEN MACROSCOPIC AND CHEM STRIP TESTS ARE NEGATIVE. MICROSCOPIC EXAM WILL BE DONE WHEN ANY URINE MACROSCOPIC OR CHEM STRIP TEST IS POSITIVE.

MICROSCOPIC

[0-2 /LPF] 0-2 SOUAMOUS EPITH NONE [0-4]NONE 0-4 WBC/HPF NONE [0-3] /HPF] NONE RBC/HPF 2 +* NEGATIVE, [NEGATIVE] BACTERIA [NEG/LPF] 0-3* FINE GRAN CAST [NEG/LPF] 1 +* AMORPHOUS

000228

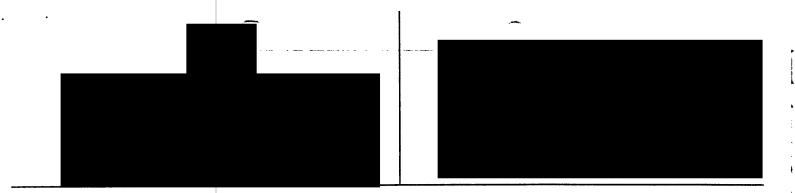
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* = Abnormal

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LABORATORY REPORT



BODY FLUID ANALYSIS - 12 - 14

DATE 03/20/99 03/20/99 TIME 1645 1330 SAT DAY SAT

UNITS REFERENCE RANGE PROCEDURE

CSF ANALYSIS

CSF PROTEIN

CSF CSF SOURCE CSF TUBE # TUBE 2 YELLOW* [NO COLOR] CSF COLOR HAZY* CSF APPEARANCE CSF XANTHOCHROM 3+* _ MM3 [0-5]**22**H CSF WBC COUNT 3938H -MM3 [0-0]CSF RBC ક્ર [2-4]3 CSF NEUT % 윰 [40 - 80]82H CSF LYMPHS% ક 15L [20-40]CSF MONO/MACRO% mq/dl [40-70]88H CSF GLUCOSE

689Hf

03/20/99 1330 RESULTS REPEATED AND VERIFIED SPECIMEN XANTHOCHROMIC

BODY FLUID ANALYSIS

FLUID SOURCE FOOTNOTE*f 03/20/99 1645 ABDOMINAL FLUID

YELLOW FLUID COLOR HAZY* BF APPEARANCE MM3 BF RBC COUNT 260 BF WBC COUNT MM3 3541

FOOTNOTE * f BF NEUT %

> 03/20/99 1645 UNABLE TO PREFORM DIFF DUE TO PROTEIN MESH INTERFERENCE PREVENTING ADEQUATE

mg/dl [12-60]

STAINING OF CELLS. APPEARS TO PREDOMINANTLY NEUTROPHILS.

footnote* BF LYMPHS %

FOOTNOTE* BF MONO/MACRO%

000229

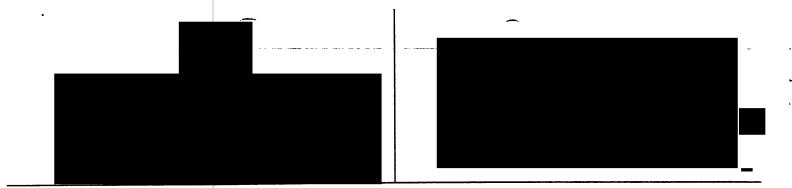
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Legend:

L = Low, H = High, * = Abnormal, f = Footnote

PAGE: 12 CONTINUED ON NEXT PAGE

LABORATORY REPORT DISCHARGE - FINAL MEDICAL RECORDS



GHENISTRY THE

	Ī	DATE TIME DAY _	03/24/99 0500 WED	03/18/99 0614 THU	03/17/99 1500 WED	UNITS	REFERENCE RANGE	2
	ELECTROLYTES SODIUM POTASSIUM CHLORIDE CO2 ANION GAP		137 4.2 100 29 8	137 3.8 99 29 9	136 L 3.9 . 99 . 26	mmol/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]	
	INORGANIC/ORG GLUCOSE CREATININE, SER BUN SERUM CALCIUM PHOSPHORUS BILIRUBIN TOTAL TOTAL PROTEIN ALBUMIN MAGNESIUM		98 0.6L 6L 8.5 4.7H	0.6L 6L 0.9 5.7L 2.7L	135H 0.7L 6L 8.6 3.5	mg/dl mg/dl mg/dl mg/dl g/dl	[65-105] [0.8-1.5] [9-20] [8.4-10.2] [2.4-4.4] [0.2-1.3] [6.3-8.2] [3.5-5.0] [1.3-1.9]	
3	ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE	aus and Camering		29 10L 114 419H <30* 42		U/L U/L U/L U/L U/L U/L	[21-72] [17-59] [38-126] [15-73] [30-120] [23-300]	. San a Pe lla a a san a

000230

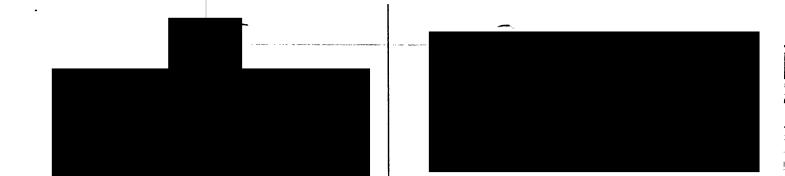
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L = Low, H = High, * = Abnormal

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LABORATORY REPORT



CHEMISTRY 2

PROCEDURE	DATE TIME DAY _	03/14/99 1920 SUN	03/05/99 2123 FRI	02/27/99 1230 SAT	UNITS	REFERENCE RANGE	
ELECTROLYTE SODIUM POTASSIUM CHLORIDE CO2 ANION GAP	s			140 4.0 . 101 . 35H 4L	MMOL/L MMOL/L MMOL/L MMOL/L MMOL/L	[137-145] [3.6-5.0] [98-107] [22-30] [8-16]	
INORGANIC/OF BILIRUBIN TOT TOTAL PROTEIN ALBUMIN	AL	0.6 6.7 3.7	0.4		MG/DL G/DL G/DL	[0.2-1.3] [6.3-8.2] [3.5-5.0]	
ENZYMES ALT AST ALK PHOS GGT AMYLASE LIPASE		70 15L 88 181H 39	94H 31 87 182H		U/L U/L U/L U/L	[21-72] [17-59] [38-126] [15-73] [30-120]	- 440

000231

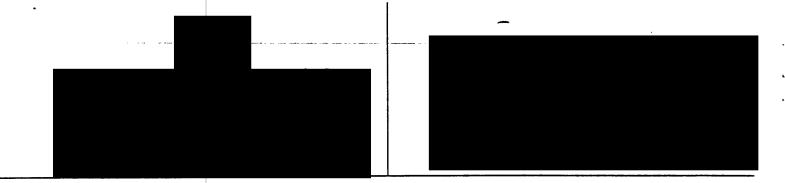
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L = Low, H = High

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LABORATORY REPORT



THERAPEUTIC DRUGS

DATE TIME DAY 03/25/99 0600 THU 03/24/99 0500 WED 03/24/99 0230 WED

PROCEDURE

UNITS F

REFERENCE RANGE

ANTIBIOTICS

VANCO PEAK

18.4L

ug/ml

THERAPEUTIC RANGE: 30-40 UG/ML TOXIC: GREATER THAN 80 UG/ML

ANTICONVULSANTS

PHENYTOIN

11.9

4.2L

ug/ml

THERAPEUTIC RANGE: 10-20 UG/ML TOXIC: GREATER THAN 25 UG/ML

DATE

03/23/99

TIME DAY 2330 TUE

PROCEDURE

UNITS

REFERENCE RANGE

ANTIBIOTICS

VANCO TROUGH-

THERAPEUTIC RANGE: 5-10 UG/ML

TOXIC: GREATER THAN 80 UG/ML

000232

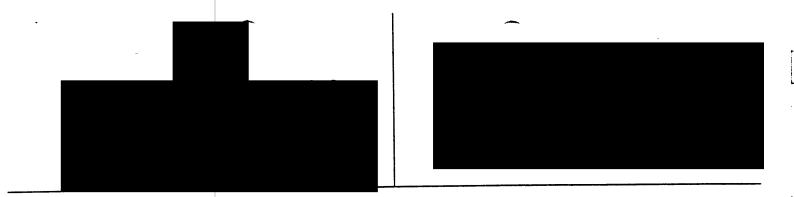
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3.7L ug/ml ug/ml

PAGE: 15

LABORATORY REPORT



HEPATITIS TESTING

DATE

03/20/99

TIME

1735

DAY

UNITS

REFERENCE RANGE

HEPATITIS C AB

NEGATIVE

HBsAg

NEGATIVE

HAV AB IGM

PROCEDURE

NEGATIVE

ANTI-HBs

NEGATIVE

03/20/99 1735 QUANT ANTI-HBS RESL 0.00 MIU/ML

COMMENT: NOT IMMUNE

[NEGATIVE]

[NEGATIVE]

[NEGATIVE]

[NEGATIVE]

ORDERED PROCEDURES THAT ARE PENDING

03/20/99 1654 1403 03/20/99

ROUTINE FUNGAL CULTURE STERILE SITE CULTURE

PRELIM PRELIM

CANCELLED ORDERS

MD REQUEST

HEMOGRAM + PLT + DIFF

03/17/99 1801

000233

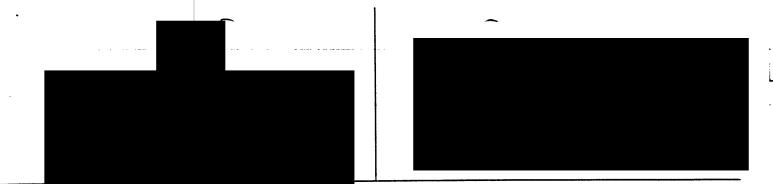
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f = Footnote

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LABORATORY REPORT



CANCELLED ORDERS

DUPLICATE

RN REQUEST

RN REQUEST

DUPLICATE

RN REQUEST

RN REQUEST

RN REQUEST

RESCHEDULE

RN REQUEST

RN REQUEST

DUPLICATE

02/27/99 2319 PARTIAL THROMBOPLASTIN TIME INR GROUP 02/27/99 1341 02/27/99 1341 PARTIAL THROMBOPLASTIN TIME PARTIAL THROMBOPLASTIN TIME 02/27/99 2319 02/27/99 1341 INR GROUP PARTIAL THROMBOPLASTIN TIME 02/27/99 1341 02/27/99 1214 INR GROUP PARTIAL THROMBOPLASTIN TIME 02/27/99 1214 02/27/99 1214 INR GROUP PARTIAL THROMBOPLASTIN TIME 02/27/99 1214 PARTIAL THROMBOPLASTIN TIME 02/27/99 1214

COOP CULINES

BLOOD CULTURE SOURCE: BLOOD

BLOOD RT HAND SET#2

COLLECTED: 03/20/99 0150 RECEIVED: 03/20/99 0304

STARTED: 03/20/99 0500

-----FINAL REPORT-----03/25/99 0942

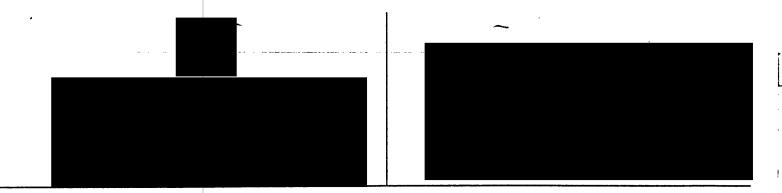
NO GROWTH AT 5 DAYS

000234

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PAGE: 21

LABORATORY REPORT



BLOOD CULTURES

BLOOD CULTURE

SOURCE: BLOOD

BLOOD RAC #1 SET

COLLECTED: 03/20/99 0125 RECEIVED: 03/20/99 0302

STARTED: 03/20/99 0500

_COLLECTED: 03/20/99 0816

RECEIVED: 03/20/99 0816

STARTED: 03/20/99 0953

--FINAL REPORT----03/25/99 0942

NO GROWTH AT 5 DAYS

URINE CULTURES !!

URINE CULTURE SOURCE: URINE

URINE

---FINAL REPORT-----03/22/99 0807

and the second s

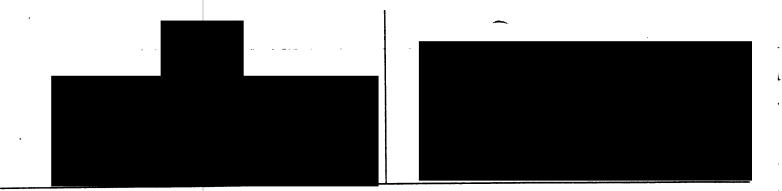
NO GROWTH

000235

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PAGE: 22

LABORATORY REPORT



FACE STERILE BODY FLUIDS

STERILE SITE

SOURCE: ABDOMINAL FLUID
ABD FLUID

COLLECTED: 03/20/99 1500 RECEIVED: 03/20/99 1654 STARTED: 03/20/99 1700

----STAINS/PREPS REPORT---

GRAM STAIN FEW WBC'S SEEN NO ORGANISMS SEEN

> -----AMENDED REPORT-----03/25/99 1524

03/21/99 0759

ONE COLONY STAPHYLOCOCCUS EPIDERMIDIS
ONE COLONY CORYNEBACTERIUM SPECIES NOT JEIKEIUM
.

FINALIZED IN ERROR. CULTURE WILL BE HELD FOR 2 WEEKS.

--SUSCEPTIBILITY REPORTS--

STAEPI		MIC	INTERP	COST/UNIT	S NOTES
	OXACILLIN	>2	R	\$	
	GENTAMICIN	<=1	S	\$\$	LEVELS AFTER 3RD DOSE
	VANCOMYCIN	<=2	S	\$\$\$	
	CIPROFLOXACIN	>2	R	\$\$\$\$\$	FACULTY SIGNATURE WITHIN 24 HR
	SXT	<=2/38	S	\$\$	
	RIFAMPIN	<=1	s	\$	

STERILE SITE

SOURCE: CEREBROSPINAL FLUID

CSF

COLLECTED: 03/20/99 1330

RECEIVED: 03/20/99 1403 STARTED: 03/20/99 1406

GRAM STAIN RARE WBC'S SEEN NO ORGANISMS SEEN ----STAINS/PREPS REPORT--03/20/99 1429

----[']PRELIMINARY REPORT----03/21/99 0750

NO GROWTH TO DATE

000236

CONTINUED ON NEXT PAGE

PAGE: 23

LABORATORY REPORT



A COULTURES THE CULTURES THE COULTURES THE

ANAEROBIC CULT

SOURCE: ABDOMINAL FLUID

ABD FLUID

COLLECTED: 03/20/99 1500 RECEIVED: 03/20/99 1654

STARTED: 03/20/99 1700

----STAINS/PREPS REPORT--03/22/99 1339

GRAM STAIN
FEW WBC'S SEEN
NO ORGANISMS SEEN

-----FINAL REPORT-----03/25/99 1432

NO ANAEROBES ISOLATED AFTER FIVE DAYS

SICOLEXAMINATION CONTRACTOR

CLOS DIFF

SOURCE: STOOL

STOOL

COLLECTED: 03/18/99 1230

RECEIVED: 03/18/99 1340

STARTED: 03/18/99 1340

-----FINAL REPORT-----03/19/99 1646

NO C. DIFFICILE TOXIN DETECTED

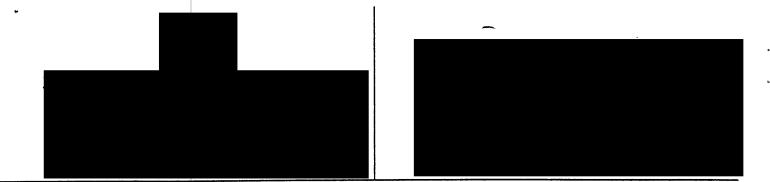
ANALYSIS PERFORMED AT

000237

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PAGE: 24

LABORATORY REPORT



FUNGAL CULTURES.

ROUTINE FUNGAL

SOURCE: ABDOMINAL FLUID

ABD FLUID

COLLECTED: 03/20/99 1500 RECEIVED: 03/20/99 1654 STARTED: 03/20/99 1700

---PRELIMINARY REPORT----03/21/99 1214

CULTURE IN PROGRESS

REFERENCE LABIDENTIFICATION IN

(THROMBIN TIME) 03/05/99 2123 THROMB TIM 1735 HEP CAB (HEPATITIS C AB) 03/20/99 03/20/99 1735 HEP BSAB (ANTI-HBs) (HBsAg) HEP BSAG 03/20/99 1735 HEP A IGM (HAV AB IGM) 03/20/99 1735

(CLOS DIFF) 03/18/99 1230 C CLOS TOX

ANTIBIOTIC PRADENAMES

GENERIC NAME

TRADE NAMES

OXACILLIN GENTAMICIN VANCOMYCIN

PROSTAPHLIN GARAMYCIN VANCOCIN

BACTOCILL **JENAMICIN** VANCOLED

LYPHOCIN

CIPROFLOXACIN SXT

CIPRO BACTRIM

SEPTRA

COTRIM

SULFATRIM

UROPLUS SS

SULFATRIM

HELVEPRIM

RIFAMPIN

RIFADIN

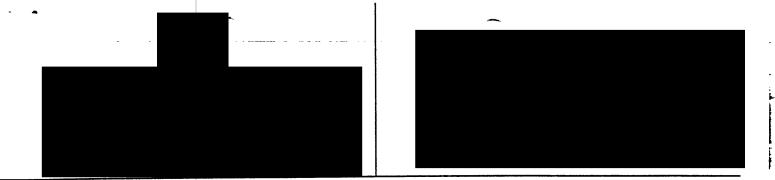
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000238

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END OF REPORT

LABORATORY REPORT



ORDERED PROCEDURES THAT ARE PENDING

03/20/99 1654

ROUTINE FUNGAL CULTURE

PRELIM

STERILE BODY FLUIDS

STERILE SITE

SOURCE: ABDOMINAL FLUID

ABD FLUID

COLLECTED: 03/20/99 1500

RECEIVED: 03/20/99 1654 STARTED: 03/20/99 1700

---STAINS/PREPS REPORT---03/21/99 0759

GRAM STAIN FEW WBC'S SEEN NO ORGANISMS SEEN

> ----AMENDED REPORT-----04/03/99 0955

ONE COLONY STAPHYLOCOCCUS EPIDERMIDIS

ONE COLONY CORYNEBACTERIUM SPECIES NOT JEIKEIUM

NO ADDITIONAL GROWTH AFTER 2 WEEKS.

--SUSCEPTIBILITY REPORTS--

STAEPI		MIC	INTERP	COST/UNITS	
	ILLIN ****	>2	R	\$	
GENI	AMICIN	<=1	S	\$\$	LEVELS AFTER 3RD DOSE
VANC	OMYCIN	<=2	S	\$\$\$	
CIPR	OFLOXACIN	>2	R	\$\$\$\$\$	FACULTY SIGNATURE WITHIN 24 HR
SXT		<=2/38	S	\$\$	
RIFA	MPIN	<=1	S	\$	

STERILE SITE SOURCE: CEREBROSPINAL FLUID

CSF

COLLECTED: 03/20/99 1330 RECEIVED: 03/20/99 1403

STARTED: 03/20/99 1406

---STAINS/PREPS REPORT---03/20/99 1429

GRAM STAIN

RARE WBC'S SEEN

NO ORGANISMS SEEN

----FINAL REPORT-----04/03/99 0950

NO GROWTH AFTER TWO WEEKS

000239

CONTINUED ON NEXT PAGE

PAGE: 1

LABORATORY REPORT



ANTIBIOTICTRADE NAMES

GENERIC NAME

TRADE NAMES

OXACILLIN
GENTAMICIN
VANCOMYCIN
CIPROFLOXACIN
SXT

PROSTAPHLIN GARAMYCIN VANCOCIN CIPRO BACTRIM UROPLUS SS

RIFADIN

BACTOCILL JENAMICIN VANCOLED

LYPHOCIN COTRIM

HELVEPRIM

SULFATRIM

RIFAMPIN

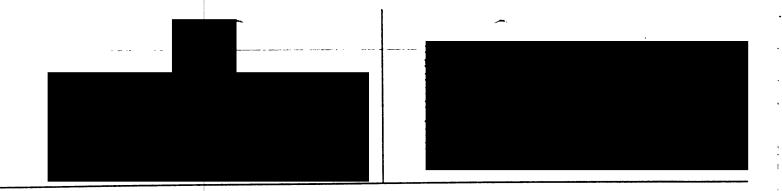
SEPTRA SULFATRIM RIMACTANE

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000240

END OF REPORT

LABORATORY REPORT



ORDERED PROCEDURES THAT ARE PENDING

03/20/99 1654

ROUTINE FUNGAL CULTURE

PRELIM

FUNGALCUTURES

A CALL OF THE RESIDENCE OF THE PARTY OF THE

ROUTINE FUNGAL

SOURCE: ABDOMINAL FLUID

ABD FLUID

99-079-0322

COLLECTED: 03/20/99 1500

RECEIVED: 03/20/99 1654

STARTED: 03/20/99 1700

----PRELIMINARY REPORT---04/06/99 1303

NO GROWTH TO DATE

000241

END OF REPORT

LABORATORY REPORT





FINAL

REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 02/27/99

TIME: 1547

ACCESSION #

REPORT

DATE OF SERVICE: 02/27/99; 1547.

PROCEDURE PERFORMED: CT head.

REFERRING PHYSICIAN:

M.D.

CLINICAL HISTORY:
A 29-year-old male status post partial right hemispherectomy for follow-up of shunt.

المسترسور مجي

TECHNIQUE:

Serial axial images were obtained of the head from the level of the foramen magnum to the vertex without the use of an intravenous contrast agent. Bone windows were obtained as well.

FINDINGS:

No prior studies are available for comparison at this time. The patient is status post right frontotemporal parietal craniotomy for apparent partial right hemispherectomy. Portions of the basal ganglia and thalamus are still present on the right as well as the region of the uncus and posterior, inferior and medial aspect of the frontal lobe. A ventricular shunt catheter is seen with coursing through the right hemispheric CSF collection. There is asymmetry of the lateral ventricles, the left larger than the right with left to right midline shift. There is moderate prominence of the inferior third ventricle as well as the frontal and temporal horns on the left. The fourth ventricle is unremarkable. Thin, low density extra-axial fluid collection is seen in the left frontal region which results in mild mass effect. There is an extra-axial fluid collection adjacent to the CSF cavity in the right hemisphere.

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PAGE: 1 CONTINUED

FORM. #:

FINAL

EXAM:

CT HEAD WO/CONT

DATE:

TIME:

ACCESSION #

02/27/99 1547

IMPRESSION

IMPRESSION:

Status post operative changes as described with bilateral extra-axial fluid collections and ventricular dilatation as described above. While this may represent hydrocephalus, comparison with prior study is necessary to evaluate interval change. Clinical correlation is advised.

Dictated by:

M.D.

D: 02/28/99; 0756

Job

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SIGNED BY: RESIDENT ID: M.D.

T: 01MAR1999

S: 03MAR1999

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REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 03/11/99

TIME: 0513

ACCESSION #

REPORT

CLINICAL HISTORY:

This is a 29-year-old male patient status post stroke and subsequent decompressive surgery. Referred for follow-up evaluation.

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

There is an encephalomalacic region occupying much of the right hemisphere. The right thalamus has been preserved. A small portion of the posterior frontal paramedian region has been preserved. There is marked midline shift towards the right due to volume loss on the right. There is ex vacuo enlargement of the left lateral ventricle. A subdural collection is present over the left convexity. This is small. No recent infarcts are seen. A drain is present on the right in the encephalomalacic region and appears to communicate with the ventricular system.

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EXAM:

CT HEAD WO/CONT

DATE: 03/11/99

TIME: 0513

ACCESSION #

IMPRESSION

Large encephalomalacic cavity present on the right with volume loss and midline shift towards the ipsilateral site. In addition, there is a small subdural collection over the left frontal convexity. No recent infarct or hematoma is seen.

Dictated by:

M.D.

D: 03/11/99; 1433

Job

المانية المعالمة

SIGNED BY: RESIDENT ID:

M.D.

T: 12MAR1999 S: 12MAR1999

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FINAL

REFERRING PHYSICIAN:

DATE:

TIME: 0539

ACCESSION #

CT HEAD WO/CONT

REPORT

03/15/99

CLINICAL HISTORY:

This is a patient with a history of previous right middle cerebral artery infarct, who has had resection of his right hemisphere.

TECHNIOUE:

7 mm contiguous axial slices through the brain are obtained without intravenous contrast.

FINDINGS:

The current study is correlated with the previous study from 03/11/99. There is again, evidence of resection of a large portion of the right hemisphere involving the frontal, parietal, temporal and occipital lobes. The basal ganglia remains. A large ex vacuo fluid collection is seen in the region of the resection site and there is herniation of the remaining brain across the midline. The configuration is similar to that on 03/11/99. The shunt tube present within the fluid collection on the right is unchanged in position. The lateral ventricular size on the left is unchanged. The fourth ventricular size is unchanged. The parenchyma of the left hemisphere is unchanged. No new abnormalities in the posterior fossa are seen. There continues to be an extra-axial fluid collection overlying the left frontal convexity that now contains mixed density and some areas of high density along its inferior aspect. This likely reflects some acute hemorrhage into this extra-axial, likely subdural fluid collection, and it does appear slightly larger than on 03/11/99, indenting the frontal lobe slightly more on axial slices #10, #11 and #12. No other new findings are seen. The bony abnormalities from the right frontal and parietal craniotomy are again noted. The visualized paranasal sinuses are well aerated.

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PAGE: 1 CONTINUED

FORM #:

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 03/15/99 TIME: 0539

ACCESSION #

IMPRESSION

1. Acute hemorrhage into a left frontal extra-axial, likely subdural fluid collection. This has occurred since the previous scan dated 03/11/99, and this collection has slightly increased in size related to the re-hemorrhage with slightly more mass effect upon the left frontal lobe.

Otherwise, no significant change relative to 03/11/99.

Dictated by:

M.D.

D: 03/15/99; 1046

Job

SIGNED BY: RESIDENT ID:

T: 16MAR1999

S: 22MAR1999 *** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

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		FINAL			
3	EXAM: CT ABD W/CONTRAST CT PELVIS W/CONT	DATE: 03/15/99 03/15/99 IMPRESSION	TIME: 1228 1228	ACCESSION #	-
	 Fluid filled right coledema or inflammatory colon. Borderline splenic siz Dependent changes of t 				

M.D.

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Dictated by:

SIGNED BY:

RESIDENT ID:

T: 16MAR1999 S: 16MAR1999

ADM DXS CODE:

Job |

D: 03/15/99; 1313



PATIENT : MRN VISIT # PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC

ROOM



FINAL

REFERRING PHYSICIAN:

EXAM:

CT ABD W/CONTRAST CT PELVIS W/CONT

DATE: 03/15/99 TIME: 1228 1228

ACCESSION #

03/15/99

REPORT

CLINICAL HISTORY:

Left shift and abdominal pain.

TECHNIQUE:

7 mm contiguous transaxial images through the abdomen and pelvis were performed with intravenous and oral contrast enhancement. No prior CT's were available for comparison.

FINDINGS:

Images reveal the patient's left upper extremity to overlie the upper abdomen. A ventriculoperitoneal shunt is seen entering the mid-upper abdomen with the tip just lateral to the stomach on image #22. No associated fluid collection is present. Some confluent parenchymal disease is seen posteriorly on the right much greater than the left, likely related to atelectasis. The liver is unremarkable. A borderline spleen is seen measuring 12.0 x 8.0 x 10.5 cm. The pancreas and adrenals are normal. A gallbladder is identified. The kidneys are normal in appearance. No adenopathy is seen. No free or loculated fluid collections are appreciated. Some fluid is seen in the ascending colon through the hepatic flexure and mid-transverse colon. Of note, are some strandy changes consistent with edema or inflammation in the fat anterolateral to the right colon. I am unable to identify the appendix. A Foley catheter is in place.

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EXAM: ABDOMEN AP DATE: TIME: 03/15/99 0528

ACCESSION #

IMPRESSION

 Nonspecific, nonobstructive bowel gas pattern.
 Transitional thoracolumbar segment with five free-standing lumbar segments below that level.

3. A curvilinear density in the left upper quadrant may be the patient's ventriculoperitoneal shunt line.

Dictated by:

M.D.

D: 03/15/99; 1150

Job

SIGNED BY: RESIDENT ID: M.D.

T: 16MAR1999

S: 16MAR1999

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	REFERRING	PHYSICIAN:					•	•
	EXAM: PORTABLE	CHEST X-RAY		DATE: 03/15/99	TIME: 1202	ACCESSION #	ı	
				REPORT				
	CLINICAL HISTORY: This is a 29-year-old neurosurgical patient who is said to have infiltrate.							
	FINDINGS: An AP portable view of the chest was obtained on 03/15/99 at 1200. The heart size is normal. The lungs are moderately well expanded and I do not see any evidence of pleural fluid or pneumothorax. No pulmonary infiltration is apparent.							
				IMPRESSION	ī			
	Negative portable view of the chest.							
	Dictated	by:	M.D.					
0	D: 03/15 Job#	5/99; 1126						
	SIGNED BY RESIDENT			M.D.				
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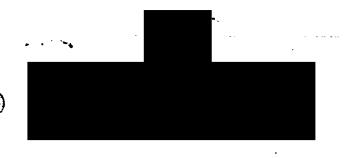
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FORM #:

ADM DXS CODE:



FINAL

REFERRING PHYSICIAN:

DATE:

TIME: 0528

ACCESSION #

REPORT

03/15/99

CLINICAL HISTORY:

This is a 29-year-old neurosurgical patient with abdominal pain. that he has a ventriculoperitoneal shunt.

FINDINGS:

EXAM:

ABDOMEN AP

AP supine portable views of the abdomen were obtained on 03/15/99 at 0530 and at 0700. The technique and positioning vary slightly between these two films. There is a small amount of gas in the stomach. Gas and some fecal material are seen in the colon. No distended bowel loops are evident. The left kidney and psoas shadow are better defined than the right. There is a calcific density in the left pelvis, most likely a phlebolith. A fine curvilinear density over the left upper quadrant may be the patient's ventriculoperitoneal shunt line. There is a transitional thoracolumbar segment with five free-standing lumbar segments below that level.

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FORM" #:





FINAL

REFERRING PHYSICIAN:

EXAM ·

CT HEAD WO/CONT

DATE: 03/16/99

TIME: 0155

ACCESSION #

REPORT

CLINICAL HISTORY:

This is a patient with a history of previous right middle cerebral artery infarct. He has had resection of the right hemisphere as treatment for edema. He has recently been found to have a small left frontal extra-axial hematoma. This is a follow-up scan.

TECHNIQUE:

7 mm contiguous axial slices through the brain are obtained without intravenous contrast.

FINDINGS:

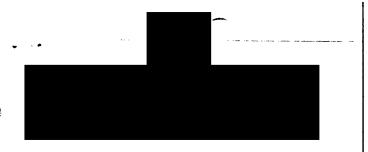
The current study is correlated with the previous examination from 03/15/99. Again, is noted a mixed density extra-axial collection overlying the left frontal convexity with areas of low density, as well as areas of higher density consistent with acute on more chronic hemorrhage. The overall size of this collection is unchanged relative to yesterday's examination; however, there is more high density noted along the posterior and superior aspect of this collection, best seen on axial slices #15, #16 and #17 near the vertex overlying the posterior left frontal lobe. This may represent more acute hemorrhage situated posterior within this collection; however, dependent layering of cellular elements may contribute to this appearance. The volume of the extra-axial collection in this region does not appear significantly changed relative to yesterday's examination, favoring dependent layering. Mild mass effect is exerted upon the left frontal lobe with indentation of the cortex and some effacement of the associated sulci. The ventriculostomy tube situated within the fluid filled cavity corresponding to the area of right hemispheric resection is unchanged. No new mass effects are seen. No new areas of intraparenchymal hemorrhage are seen. The left lateral ventricle is unchanged in size. The fourth ventricle is midline.

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FORM-#:



PATIENT : MRN ----VISIT # : PMH MRN: DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

CT HEAD WO/CONT

DATE:

03/16/99

TIME: 0155

ACCESSION #

IMPRESSION

- 1. Mixed density extra-axial fluid collection overlying the left frontal convexity, unchanged in size relative to yesterday's examination. There is some increased density noted along the posterior and superior aspect of this collection that likely relates to dependent layering of cellular elements related to acute hemorrhage rather than re-hemorrhage. Overall, the size of this collection is stable relative to yesterday's examination.
- 2. Postoperative changes from resection of a large portion of the right hemisphere, unchanged.
- 3. Ventriculoperitoneal shunt tube present within the resection site on the right, unchanged.
- 4. Basically, the exam is stable relative to yesterday's examination.

Dictated by:

M.D.

D: <u>03/16/99</u>; 0925

Job

MD

SIGNED BY: RESIDENT ID:

16MAR1999 S: 18MAR1999

ADM DXS CODE:

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REFERRING PHYSICIAN:

EXAM: CT HEAD WO/CONT **DATE:** 03/17/99

TIME: 0246

ACCESSION #

REPORT

CLINICAL HISTORY:

The patient is a 29-year-old male with hydrocephalus and a left subdural. The exam is requested for follow-up.

TECHNIQUE:

Contiguous axial images of the brain were obtained without intravenous contrast and compared with a previous CT scan from 03/16/99. Bone and soft tissue windows are reviewed.

FINDINGS:

Postoperative changes from near complete resection of the right cerebral hemisphere are re-demonstrated. Mixed attenuation of the left-sided frontoparietal subdural hematoma is again identified, which is stable in size. There is shift of midline structures to the right, which is also unchanged. No new areas of hemorrhage or mass effect are identified. A right parietal catheter remains unchanged in position. This catheter courses inferiorly, with the tip ending the near the right petrous bone.

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PAGE: 1 CONTINUED

FINAL

EXAM:

CT HEAD WO/CONT

DATE: 03/17/99

TIME: 0246

ACCESSION #

IMPRESSION

No significant interval change in left-sided subdural hematoma of mixed attenuation compared with the prior study of 03/16/99. Postoperative changes from near complete resection of the right cerebral hemisphere are re-demonstrated.

I personally reviewed the film(s) and the report above and concur.

Dictated by:

M.D.

D: 03/17/99; 1611

Job

SIGNED BY:

RESIDENT ID:

T: 18MAR1999 S: 22MAR1999

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FINAL

REFERRING PHYSICIAN:

EXAM:

PORTABLE KUB

DATE: 03/17/99

TIME: 0809

ACCESSION #

REPORT

CLINICAL HISTORY:

This is a 29-year-old neurosurgical patient in whom we are asked to rule out obstruction

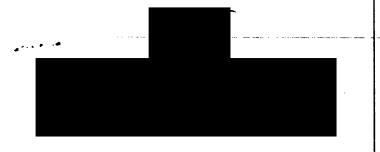
FINDINGS:

An AP supine portable view of the abdomen was obtained on 03/17/99 at 0800. There is gas and fecal material in the colon. There may be one or two loops of gas-filled small bowel in the Teft abdomen, but I am not convinced there is any obstruction. There is some gas in the stomach. Motion artifact obscures detail, and we shall be happy to obtain additional film at no charge if the patient is returned to the department. I wonder if there is some contrast material add-mixed with the stool. On the earlier film a curvilinear density is seen in the left upper quadrant, which may be a ventriculoperitoneal shunt line. I cannot identify it on today's film. There is a small left pelvic calcification consistent with a phlebolith.

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PAGE: 1 CONTINUED





FINAL

EXAM:

PORTABLE KUB

DATE: 03/17/99

TIME: 0809

ACCESSION #

IMPRESSION

1. Motion artifact obscures detail and a repeat film is recommended as clinically indicated.

There is gas and fecal material in the colon - there is no gross evidence of obstruction.

3. A curvilinear density previously seen in the left upper abdomen, which might be a ventriculoperitoneal shunt line not seen on today's film, but may be obscured by the motion.

Dictated by:

M.D

D: 04/02/99; 1638

Job

SIGNED BY: RESIDENT ID:

M.D.

T: 05APR1999

S: 06APR1999

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FINAL

REFERRING PHYSICIAN:

EXAM:

DATE:

TIME:

ACCESSION #

ABD AP/ERECT AND/OR DECUBITUS

03/18/99 0935

REPORT

CLINICAL HISTORY:

This is a 29-year-old neurosurgical patient who has left upper quadrant pain.

FINDINGS:

AP supine and upright views of the abdomen were obtained on 03/18/99 at 0948.

There is a little gas in the stomach. No distended loops of small bowel are noted. There is gas throughout the colon. The lowest portion of the pelvis is not included on the film. I have the impression that some opaque material previously in the left colon has been evacuated. I do not see any radiographic findings to suggest obstruction. A tube consistent with a ventriculoperitoneal shunt line is seen with the tip in the left upper quadrant. There is no free air beneath the diaphragm. I question some parenchymal disease at the left base.

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PAGE: 1 CONTINUED

PATIENT : MRN ----VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

ABD AP/ERECT AND/OR DECUBITUS

DATE: 03/18/99 TIME: 0935

ACCESSION #

IMPRESSION

1. A ventriculoperitoneal shunt line is seen in the left upper quadrant.

2. Otherwise, essentially unremarkable abdomen excluding the lowest portion of the pelvis.

3. Parenchymal disease is questioned in the left retrocardiac region.

Dictated by:

M.D. - رسوم

D: 03/18/99; 1512

Job

SIGNED BY: RESIDENT ID: M.D.

T: 18MAR1999

S: 19MAR1999 THE RESERVE OF THE PROPERTY OF

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PATIENT : PMH MRN: ADM DATE:

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MRN VISIT #

DOB SEX ADM MD

PT LOC ROOM

REFERRING PHYSICIAN:

DATE:

سازميني فيجيع

TIME: 1150

ACCESSION #

REPORT

03/18/99

CLINICAL HISTORY:

BARIUM ENEMA

This is a 29-year-old man who is complaining of left upper quadrant pain. He has been given GoLYTELY in preparation for colonoscopic examination and it is not felt that he has put out the volume of fluid which would normally be expected. I am asked to perform a limited Hypaque study to assess the colon for a possible obstruction.

FINDINGS:

· MAXS

The colon was filled in a retrograde fashion with Hypaque. No constricting lesions were identified and no extrinsic masses were seen. There was some residual fecal material in the colon. There was reflux of air into small bowel loops which did not appear particularly distended. A ventriculoperitoneal shunt line is seen in the left upper quadrant and there are strandy bibasilar parenchymal changes - atelectasis versus infiltration. The colon was drained and post-evacuation films showed some residual contrast throughout the colon.

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PATIENT : MRN ----VISIT # : PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

FINAL

EXAM:

BARIUM ENEMA

DATE:

TIME:

ACCESSION #

1150 03/18/99

IMPRESSION

1. No evidence of colonic obstruction.

2. Left upper quadrant ventriculoperitoneal shunt line.

3. Strandy bibasilar parenchymal disease - atelectasis versus infiltration.

Dictated by Dr.

D: 3/18/99, 1410

Job

SIGNED BY: RESIDENT ID: M.D.

18MAR1999 s: 19MAR1999

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REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 03/18/99 TIME: 0231

ACCESSION #

REPORT

CLINICAL HISTORY:

A 29-year-old male status post partial right hemispherectomy and follow-up of a left extra-axial fluid collection.

TECHNIQUE:

Serial axial images are obtained of the head from the level of the foramen magnum to the vertex without the use of an intravenous contrast agent. Bone windows are obtained as well.

FINDINGS:

Comparison is made to most recent exam of 03/17/99. As before, the patient is status post right frontotemporal parietal craniotomy for partial right hemispherectomy. A large CSF density collection is seen in the region of the resected brain. Shunt catheter is again seen to extend into this CSF collection which is not changed in overall size and shape since the prior exam. There continues to be asymmetric dilatation of the lateral ventricles, the left greater than the right, with mild prominence of the third ventricle seen and normal appearing fourth ventricle. The midline structures remain shifted from left to right and there continues to be a mixed density extra-axial fluid collection in the left frontal region extending toward the vertex, resulting in a mass effect upon the adjacent left hemisphere and sulcal effacement.

No evidence for interval hemorrhage or abnormal low density is seen to develop since the prior study.

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EXAM:

CT HEAD WO/CONT

DATE: 03/18/99 TIME: 0231

ACCESSION #

IMPRESSION

No definite significant change seen since the prior study of 03/17 with findings as described.

Dictated by:

D: 03/18/99; 0850

Job

SIGNED BY: RESIDENT ID:

8MAR1999 S: 22MAR1999

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PATIENT : VISIT # PMH MRN : DOB SEX ADM MD ADM DATE: PT LOC ROOM

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EXAM:	DATE:	TIME:	ACCESSION
CT ABD W/CONTRAST	03/20/99	1429 1429	
CT PELVIS W/CONT	03/20/99 03/20/99	1504	
CT ASPIRATION FINE NEEDLE CT GUIDE CYST ASP BODY	03/20/99	1504	

REPORT

TECHNIQUE:

Spiral CT of the abdomen and pelvis was performed using 7 mm collimation and reconstructed using 7 mm index. Both oral and IV contrast was given. The study was compared to prior CT of 03/15/99.

FINDINGS:

Sections through the lung bases demonstrate new left pleural effusion and lung consolidations. Previously seen pleural thickening and fibrotic changes in the right lung base are unchanged.

The liver, spleen, kidneys, pancreas and adrenals remain normal. Free fluid is now seen around the spleen and in the pelvis; also new since the prior exam. In some areas, the perisplenic fluid appears to be loculated with slight mass effect to the spleen. This is especially seen around the VP catheter tip. In the subcostal region superficial to the transverse colon is a 3 $1/2 \times 5 \times 5$ cm rounded fluid collection with slight enhancement of the adjacent peritoneum. The findings are consistent with a inflammatory precess. No adenopathy is seen in the abdomen or pelvis.

Following discussion with the patient's clinician, Dr. decided to perform a CT guided aspiration of the loculated fluid. The patient was consented for this procedure and the purpose and potential complications were explained to him. Using local anesthesia, using aseptic technique and with CT guidance, a 20 gauge spinal needle was placed in this fluid collection and about 5 cc of somewhat turbid, but non-odorous straw-colored fluid collection was aspirated. This sample was sent with the patient back to the floor. No immediate complications were encountered.

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PATIENT : MRN ----: VISIT # : PMH MRN : DOB SEX ADM MD • ADM DATE: PT LOC ROOM

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ACCESSION # TIME: DATE: EXAM: 03/20/99 1429 CT ABD W/CONTRAST 03/20/99 1429 CT PELVIS W/CONT 03/20/99 1504 CT ASPIRATION FINE NEEDLE 1504 03/20/99 CT GUIDE CYST ASP BODY

IMPRESSION

1. New left pleural effusion and lung consolidations.

New free fluid around the spleen and in the pelvis. Some early loculation is seen in the perisplenic fluid, especially around the VP catheter tip. Clinical correlation is needed for possible shunt obstructive symptoms.

3. Left upper quadrant possibly infected fluid collection that was aspirated with CT guidance for diagnostic purposes. See above discussion.

M.D. Dictated by:

03/20/99; 1515

Job

M.D. SIGNED BY: RESIDENT ID:

T: 22MAR1999 S: 24MAR1999

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REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 03/20/99 TIME: 0805

ACCESSION #

REPORT

CLINICAL HISTORY:

This is a 29-year-old with hydrocephalus and evaluation of a subdural hematoma.

TECHNIQUE:

7 mm contiguous noncontrast transaxial images were performed through the head and imaged utilizing a bone and soft tissue window. __

FINDINGS:

There has been prior surgery with a right-sided craniotomy performed. ventriculoperitoneal catheter has been placed and resides in the large low density right hemispheric fluid collection replacing almost the entire right hemisphere with exception of some thalamic and basal ganglial tissue. In addition, there is an acute extra-axial fluid collection underlying the left frontal bone, which measures approximately 12 mm in maximal thickness. Shift of the midline on an ex vacuo basis to the right is noted. In addition, there is enlargement of the left lateral and third ventricle. A lack of cortical sulci are seen on the left and this is due to the presence of a subdural hematoma extending up to the vertex, some of which has mixed low density within and some of the components have high density; indicating at least acute on subacute features.

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FINAL

EXAM:

CT HEAD WO/CONT

DATE:

TIME:

ACCESSION #

03/20/99 0805

IMPRESSION

Compared with a study done on 03/18/99, all the above described features are essentially stable and unchanged. No interval ventricular enlargement, nor progression of the subdural hematoma on the left is noted.

Dictated by:

M.D. .

D: 03/20/99; 1240

Job

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SIGNED BY: RESIDENT ID:

M.D.

T: 22MAR1999 S: 22MAR1999

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REFERRING PHYSICIAN:

EXAM:

CT HEAD WO/CONT

DATE: 03/24/99

TIME: 0254

ACCESSION #

REPORT

CLINICAL HISTORY:

This is a 29-year-old male patient status post a previous cerebrovascular incident, referred for follow up evaluation.

TECHNIQUE:

7 mm contiguous axial images were obtained from the skull base through the vertex without the use of an intravenous contrast agent. Bone and soft tissue images were obtained.

FINDINGS:

There is evidence of prior right frontotemporal and frontoparietal craniotomies. Much of the right hemisphere has been removed. There has been preservation of a small amount of the midline portion of the right frontal lobe. The right thalamus has been preserved. A postsurgical cavity is present where much of the lower hemisphere has been removed. This loss of volume has caused ipsilateral shift towards the right. Ventricular size is stable since the most recent prior study of 03/20. An extra-axial collection is present over the left frontal convexity which is slightly smaller and less dense than on the prior study of 03/20. No new lesions are seen.

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MRN :
VISIT # :
PMH MRN :
DOB :
SEX :
ADM MD :
ADM DATE:
PT LOC :
ROOM :

FINAL

EXAM:

CT HEAD WO/CONT

DATE:

TIME:

ACCESSION #

03/24/99 0254

AND SIGNED EDUCATION

IMPRESSION

Subdural compression over the left frontal convexity which is slightly smaller and less dense than on the prior study. However, it is still present. The remaining features are stable.

Dictated by:

M.D. ..

E.

D: 03/24/99; 0959

Job#

SIGNED BY:

RESIDENT ID:

M.D.

T: 24MAR1999 S: 24MAR1999

*** THIS DOCUMENT HAS BEEN REVIEWED AND SIGNED ELECTRONICALLY ***

000270

MEDICAL RECORDS COPY

PAGE: 2 END OF REPORT

FORM #:





Memorandum to ARMS # _________

Date: 6/9/55

From: Medical Officer, Clinical Research and Review Staff, Office of Special

Nutritionals, HFS-452

Subject: Medical Records Place in Permanent Storage.

The following types and amounts of records (more than 20 pages total) were place in permanent storage on this date because they were not considered essential for interpretation of this adverse event.

Approx Pages	Type of Records
16	Nursing notes
1	Dietitian notes
4	Respiratory therapy/occupational therapy/physical therapy notes
	Clergy notes
11/2"	Medication records
200	Physician's orders
	Vital signs, fluids, input/output records
65	Ventilator records
4	Hospital administrative records (e.g., insurance information, living will, etc)

Jan Coor